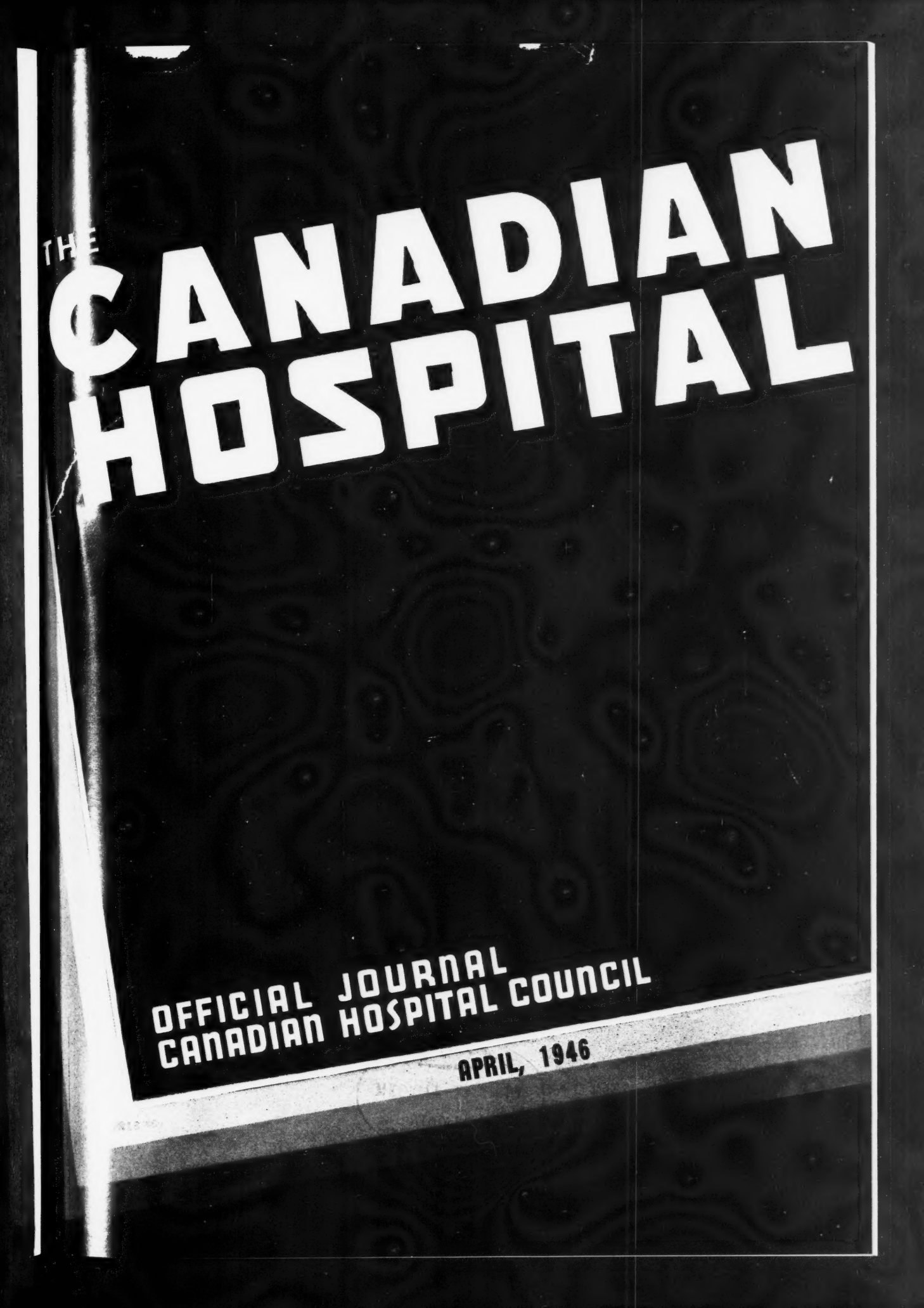
THE
CANADIAN
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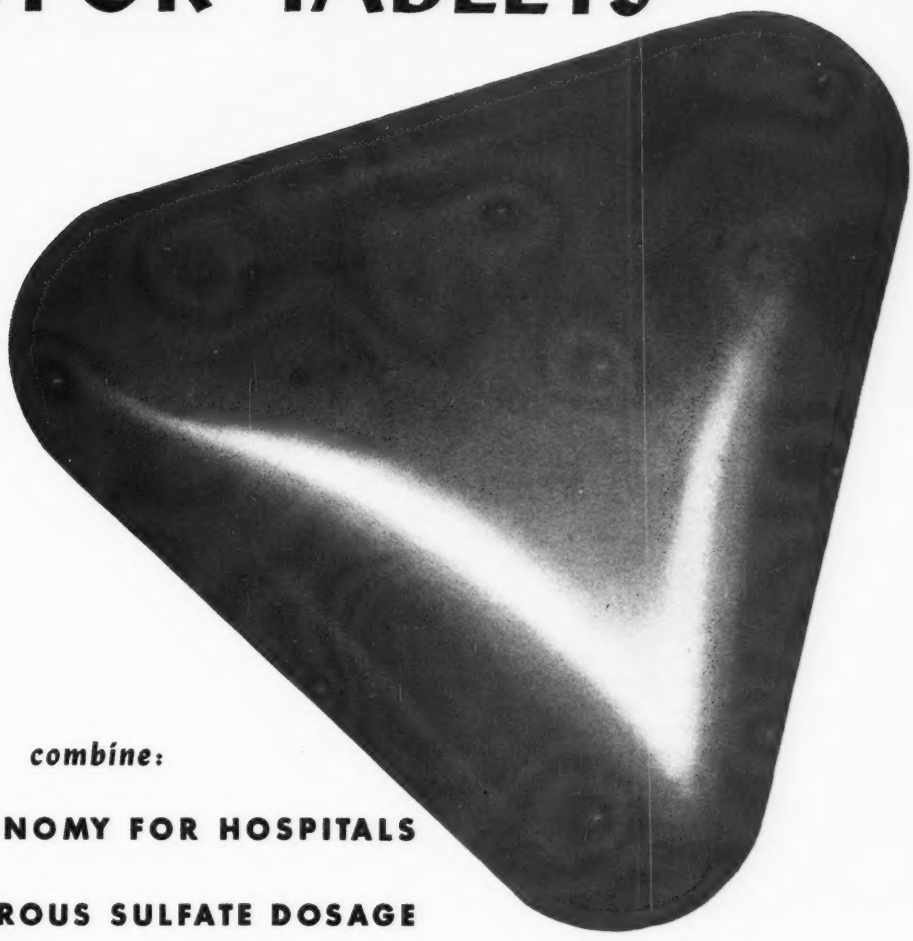
OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL
APRIL, 1946

FESOFOR TABLETS



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Contents

Vol. 23 **APRIL, 1946** No. 4

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

MEMBER

CCAB

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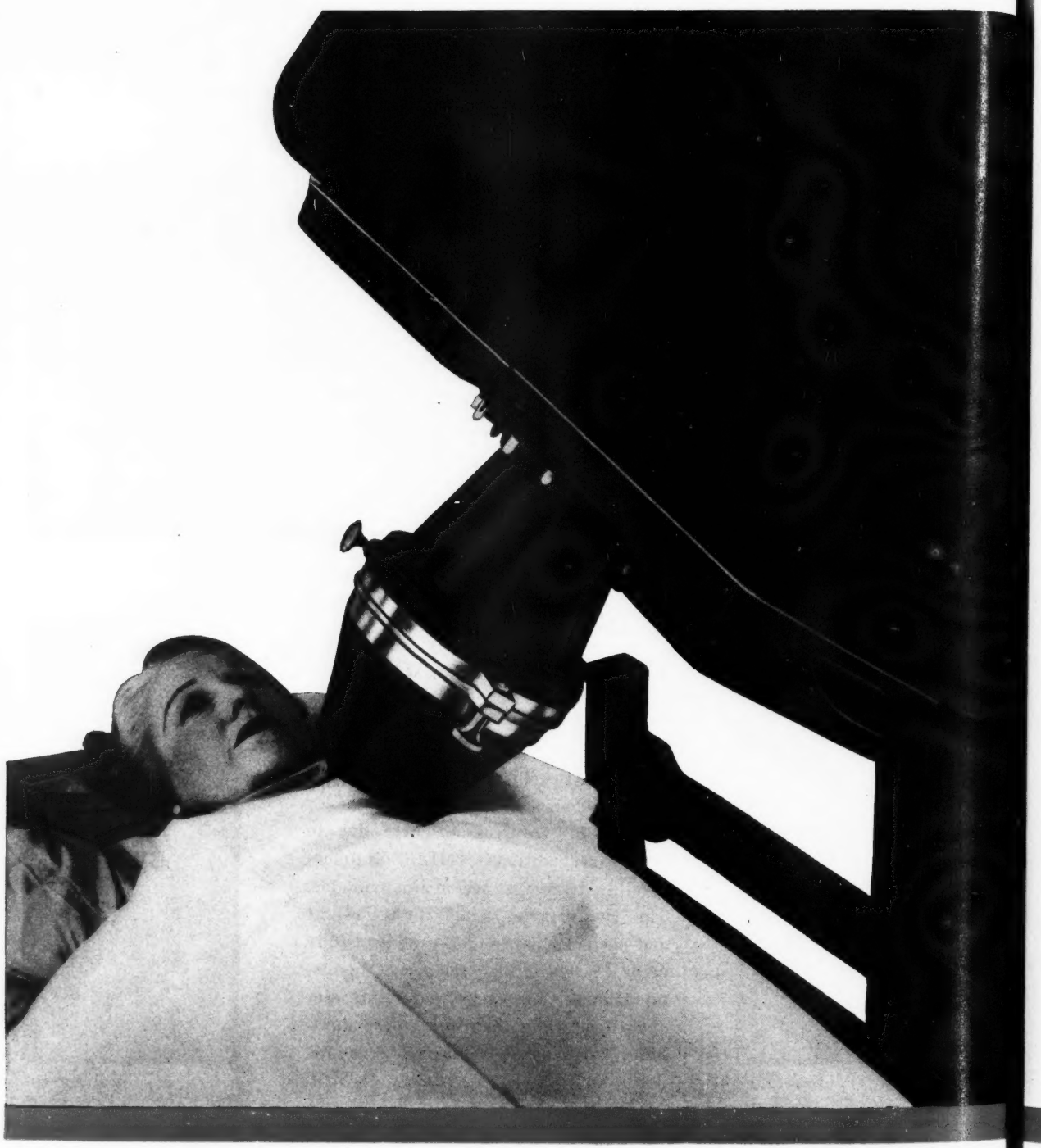

There's a G-E Maximar Therapy Unit

awaiting your logical selection

Making its bow ten years ago, the G-E Maximar Therapy Unit was indeed a radical departure from the conventional design of therapy equipment. For with its entire high-voltage system, including the Coolidge tube, completely oil-immersed in a single hermetically-sealed container or tube head, it brought to realization an unusually compact and intensely practical shock-proof unit with unprecedented flexibility of application.

Today, the G-E Maximar is famous the world over, not only as the unit of singularly practical design, but also for its high efficiency, reliability, and low cost of maintenance, as varified by the experiences—the day-to-day records—of hundreds of Maximar-equipped x-ray laboratories.

The fact that three other successively higher powered Maximar units have since been developed in response to the manifest needs of radiologists, is perhaps the most convincing evidence of the correctness of this radically different principle of design. And further confirming this are the following data, showing the enhanced x-ray output, both quantitatively and qualitatively, attained with each succeeding Maximar in its higher voltage range:

Model	Added Filter	Focal-Skin Distance	r/ma/min	% Increased Output	Half-Value Layer
200 Kv. Maximar	2 mm. Cu.	50 cm.	1.10		2.00 Cu.
*220 Kv. Maximar	2 mm. Cu.	50 cm.	1.55	40%	2.25 Cu.
250 Kv. Maximar	2 mm. Cu.	50 cm.	1.90	72%	2.45 Cu.
	3 mm. Cu.	50 cm.	1.40		3.00 Cu.
400 Kv. Maximar	2 mm. Cu.	50 cm.	5.60	500%	3.75 Cu.
	5 mm. Cu.	50 cm.	1.60		5.00 Cu.

Thus it will be seen that this series of Maximar Units has made it possible to select one which, for a given type of therapy, and in view of the number of patients to be treated daily, will adequately and most economically fulfill the individual requirements.

For still higher voltages, as desired for research in certain institutions, other G-E units are available for operation at voltages well up in the millions.

To carefully evaluate and logically select a therapy unit in light of your particular needs is obviously important. But equally important is an efficient plan for the proper installation of that unit, to assure your therapy service of all the advantages intended in its design, and it is in this phase of the project that you'll find our long experienced layout engineers mighty helpful.

* Superseded by the 250 Kv. Maximar

VICTOR X-RAY CORPORATION of CANADA, Ltd.

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ANTISEPSIS

From Obstetrics to General Purposes

'A general disinfectant must possess activity 'against the most important pathogenic organ-'isms and, it is suggested, against at least these 'three: typhoid, staphylococcus and streptococcus. 'Moreover, any claim made should be required 'to be substantiated by a test designed to prove 'activity in the particular conditions made in the 'claim. Activity in the presence of blood, serum 'or other organic matter is very important, for 'so many are ineffective in these conditions.'*

Among the original investigations of 'Dettol', not the least important was a study of its bactericidal potency against the hæmolytic streptococci responsible for the great majority of puerperal infections and its capacity to form a durable barrier against these organisms. With respect to these qualities it proved far more dependable than any of the antiseptics with which it was compared: it eliminated the organisms completely in one-and-a-half minutes; on the treated skin it provided a protective covering which could prevent re-infection for five hours; its repeated application at full strength proved harmless; on the freshly scratched skin or the vaginal mucous membrane it caused neither pain nor other irritative effects. At Queen Charlotte's, London's great maternity hospital, the introduction of this antiseptic was followed by an over 50 per cent. decline in the incidence of hæmolytic streptococcal infections.

Today 'Dettol' is preferred before all other substances not only in obstetrics, but in the operating theatre, casualty post, factory and home. For its remarkable bactericidal power is not specific to hæmolytic streptococci, but extends to such common pathogenic organisms as *Staph. aureus, Bact. typhosum* and *Bact. coli*. Surgeons, physicians and obstetricians feel secure with an antiseptic which has been shown by repeated laboratory tests, confirmed by ten years' clinical experience, to be effective – even in the presence of blood, pus and wound contaminants – and at the same time non-toxic at full strength. And patients prefer it because its application, whether to wounds, abraded surfaces or mucous membranes, does not cause pain – and because it is a pleasant preparation which, unlike poisonous antiseptics, can be left in an accessible place for the use of the whole household.

* *Berry, H.* (1944) *Pharmaceutical Journal*, **3.**

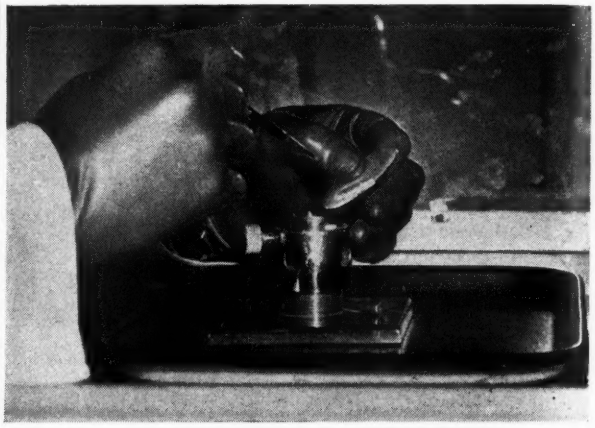
RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DEPARTMENT, MONTREAL

Across the Desk

By C. A. E.

New Radium and X-Ray Plant in Toronto

A CHECK by the Geiger-Muller counter of all persons leaving the plant is one of the safety devices incorporated in the new $75,000 X-ray and Radium Industries building just completed in Toronto. It is the only plant in Canada processing radium for medical and industrial use. A year's orders for shipment all over the world to cancer clinics exists at present.



A special jig is used to fill radium needles for hospital use.

The plant was built under the supervision of the Industrial Hygiene section of the Ontario Department of Health and no effort was spared to make it safe throughout. The usual precautions demanded by law of periodic medical examinations, diaries of exposure time; complete clothing changed before and after work and daily showers are rigidly enforced. An elaborate system of general and contamination point ventilation was installed.

One interesting innovation is the use of cheap rough wood and glass frames for working cabinets. When these become contaminated they can be burned and the radium recovered. Radium comes to the plant in bromide form and is changed by the chemists to various sulphates. Placed in needles, tubes and bombs it is sent to the National Research Council which determines exactly how much radium is in each container.

* * * *

Dr. F. S. Burke to Head Division of Blindness Control

Appointment of Dr. F. S. Burke of Ottawa as chief of the division of blindness control, Department of National Health and Welfare, has been announced by the minister, the Hon. Brooke Claxton.

As head of the new division Dr. Burke will undertake a thorough investigation of the whole problem of blindness, including prevention, treatment and training.

Prior to his present appointment Dr. Burke was in charge of the foreign relations section of the Department of Veterans Affairs and medical adviser to the Department of Finance on pensions to civilian blind.

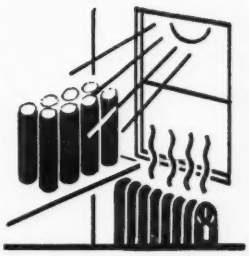
(Continued on page 16)

Timely Suggestions for the care of Adhesive Plaster

1. Don't over-stock. Adhesive plaster is made with rubber. A 90-day supply should suffice.

2. Always store rolls standing on end. Use up old before starting on new shipments of adhesive plaster.

3. Play safe. Give departments enough for immediate needs only. Sometimes, you may supply individual cuts instead of a full roll.



4. Avoid storing in the rays of the sun or near steam pipes. Too-hot temperatures cause rapid deterioration. Keep in a cool, dry room.

5. Be extra careful not to drop, squeeze, or otherwise mishandle rolls. When dented, they are very difficult to unwind.

6. Before using, let plaster warm up to room temperature (72° F.). Follow these rules and you help your hospital make supplies go further.

MADE IN CANADA

261 Davenport Rd., Toronto, 5

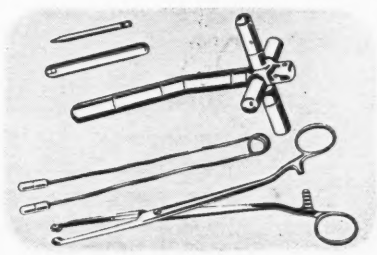
Head Office, with modern laboratories and enlarged service facilities, well-staffed with expert technicians, chemists and engineers.

*X-RAY AND RADIUM INDUSTRIES, LTD.

Because our organization has been so prominent in the development of Radium for therapeutic and industrial uses, our technical staff is now augmented to provide competent and prompt service for both X-Ray and Radium Equipment.

RADIUM APPLICATORS *and Improved* HANDLING ACCESSORIES

Illustration shows a few of the many items specially designed for modern Radium therapy, which include container units such as needles, tubes and plaques. Modern accessories are also prepared according to established medical specifications, such as protective shields, storage cabinets, forceps and screens.



UP-TO-DATE CATALOGUE SENT ON REQUEST

For the information and convenience of the medical profession, we have compiled an up-to-date catalogue of medical Radium and accessories. We will be pleased to mail this catalogue to physicians upon request. Write for your copy today.

*Formerly . . . **RADIUM LUMINOUS INDUSTRIES LTD.**

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X 26

Across the Desk

Ralph A. Hart New Appointment

Mr. C. R. Vint, president of Colgate-Palmolive-Peet Co. Limited, announces the appointment of Ralph A. Hart as vice-president in charge of sales for the Canadian Company.

"Ralph", as he prefers to be called, joined the company as a salesman in the Hamilton district in January, 1932. His exceptional sales record earned him the district managership of Ontario in January, 1934. Shortly thereafter, he was made managing director of the company's business in India where he spent almost five years, returning to Canada in 1943. In January of the following year, he was appointed sales manager for Canada.

* * * *

Walter J. Evans, R.I.A.

G. H. Wood, President and General Manager of G. H. Wood and Company, Limited, announces the election of Walter J. Evans as a Director of the Company.

As General Superintendent and Production Manager, travelling extensively throughout Canada and the United States, Mr. Evans has been responsible, to a large extent, for the development of the latest techniques and the acquisition of new products.

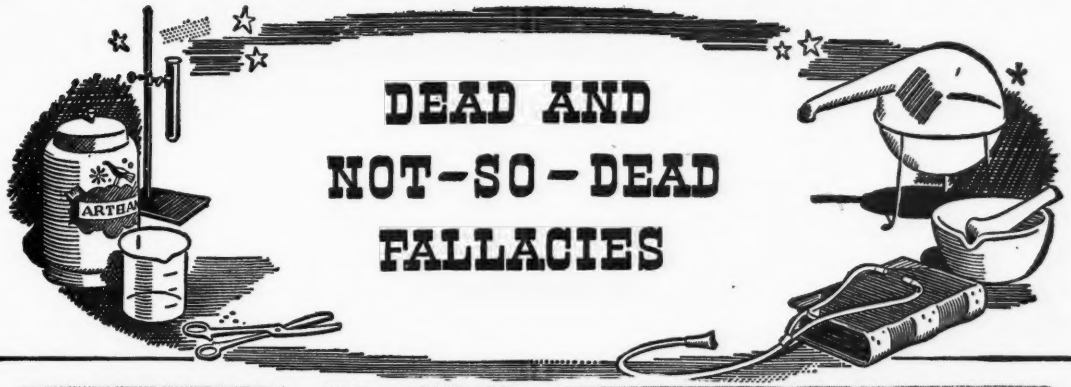
The Company's extensive building expansion programme will be under his direction.

* * * *

Junior Chamber of Commerce Campaign

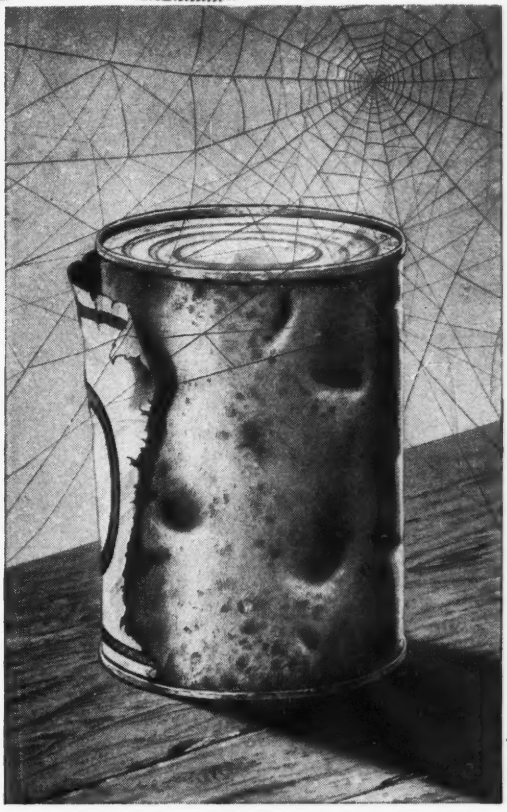
This year the National Executive of the Junior Chamber of Commerce, representing over a hundred local Junior Boards of Trade and Junior Chambers of Commerce with a membership of 20,000 young businessmen, approved a plan to coordinate and extend existing campaigns on a national basis so that the message of Clean-

(Continued on page 20)



DEAD AND NOT-SO-DEAD FALLACIES

Persons afflicted with rabies were once suspected of barking like dogs and biting anyone around them. Killing the animal which bit the victim of this disease was believed to be an effective cure.



The presence of rust on a can is looked upon by many today as a sign that the food it contains is contaminated. This, of course, is not true—unless the rust has eaten through the metal.

CANCO **AMERICAN CAN COMPANY**
MONTREAL HAMILTON TORONTO VANCOUVER

Now available on request —
"THE CANNED FOOD REFERENCE MANUAL"
—a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

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Medical Arts Building, Hamilton, Ont.

Please send me the new Canadian edition of "THE CANNED FOOD REFERENCE MANUAL," which is free.

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Professional Title .....

Address .....

City ..... Province .....

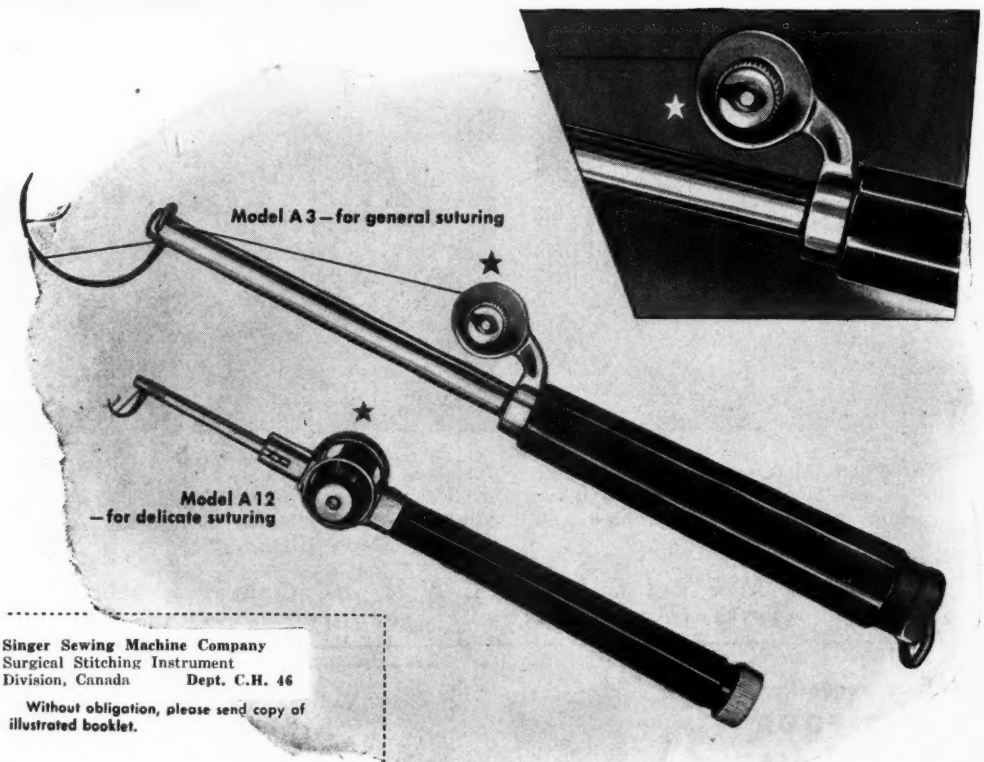
Better Surgery

THROUGH CLOSER CONTROL OF SUTURE MATERIAL

The increasing number of surgeons who are using the new Singer Surgical Stitching Instruments find particularly valuable the closer control of suturing material which these instruments afford. • The unique construction allows continuous feeding of any standard suturing material from the spool, by light pressure on the nut directly under constant thumb control—with no long, loose ends to break asepsis by contacting contaminated fields. This continuous feeding provides unprecedented suturing capacity, and shortens the time required for the suturing phase of operative procedures. • These advantages derive from the functional incorporation of needle, holder, suture supply, and (with some needles) a cutting edge—all in one single instrument. There are many other remarkable features inherent in the Singer instruments. May we forward a comprehensively illustrated booklet with full details?

SINGER

SURGICAL STITCHING INSTRUMENT



Singer Sewing Machine Company
Surgical Stitching Instrument
Division, Canada Dept. C.H. 46

Without obligation, please send copy of illustrated booklet.

Name .....

Address .....

City ..... *Prov.* .....

Our two newest films available for showing are (1) "Rehabilitation of Parkinson's Syndrome," and (2) "Treatment of Major Neuralgias."

SINGER SEWING MACHINE COMPANY, *Surgical Stitching Instrument Division*, CANADA
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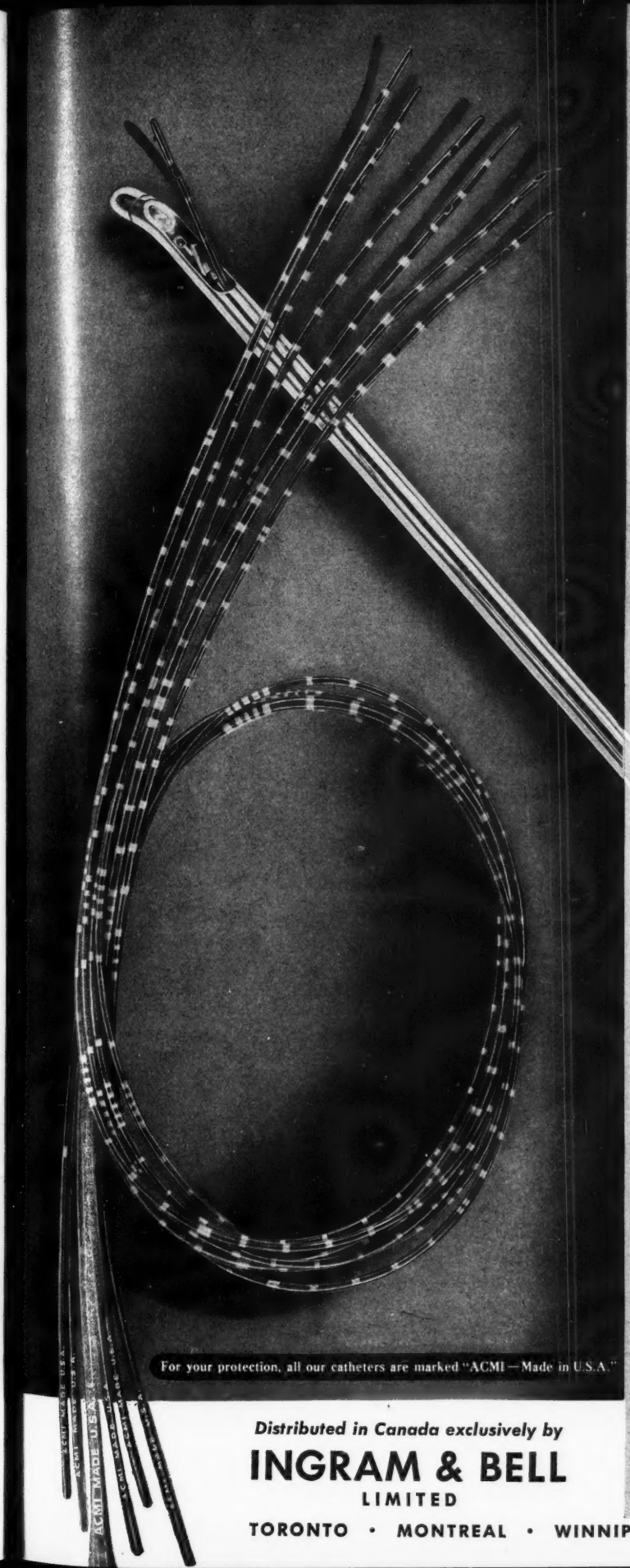
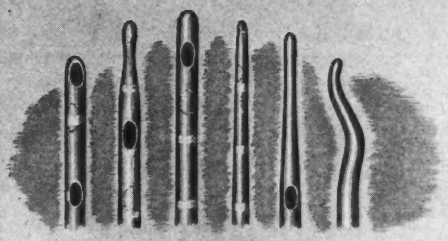


For your protection, all our catheters are marked "ACMI—Made in U.S.A."



ACMI
Woven Ureteral Catheters

Serve Better
because they're
Made Better

QUALITY OF CONSTRUCTION is never more essential for flawless performance than in ureteral catheters. Meticulous urologists prefer ACMI woven catheters because of their . . .

Physical Perfection: They're nylon woven to prevent moisture absorption that might constrict the lumen; and finished with a special baked-in resin coating that assures smooth symmetry from end-to-end, and imperviousness to body acids and salts. Eyes are woven to proper shape and proportion. Boiling or autoclaving will not destroy their original properties. X-ray opaque material is evenly distributed. The result is—

Flawless Performance: ACMI Catheters can be counted on for constant, rapid drainage. They have just the right flexibility; and their slippery surface when moist permits ready introduction. Graduation markings are accurate and clearly visible through the cystoscope.

ACMI Catheters are precise in size (with size markings clearly printed); and are available in X-ray, non X-ray, graduated and non-graduated styles; and with a variety of tips, including whistle, round, olive, and Garceau tapered tips.

AMERICAN CYSTOSCOPE MAKERS, INC.
1241 LAFAYETTE AVENUE • NEW YORK 59, N. Y.

First in Cystoscopes—First in Catheters

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LIMITED

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Across The Desk

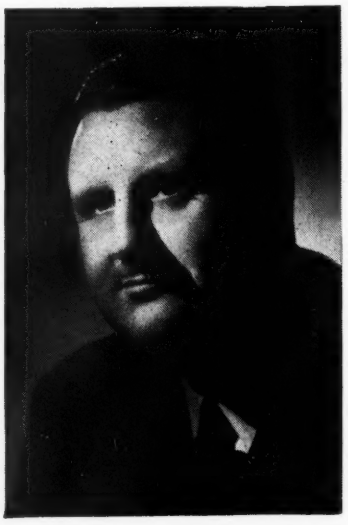
Up, Paint-Up, Plant-Up, Light-Up, Fix-Up could be carried to all Canadians from coast to coast.

Up to the present time, over forty cities and towns are planning to take part in this year's campaign and it is expected this number will be increased within the next few weeks. The project has the complete support of the Canadian Chamber of Commerce and of Senior Boards and Chambers.

* * * *

T. M. Gibson Directs Studies of Sanitation

Mr. T. M. Gibson has made a specialized study of hospital sanitation and, under his direction, the West Disinfecting Co., Ltd., has broadened and expanded its facilities to include the solution of hospital sanitation problems—not only from a building and floor maintenance standpoint—but also within the sphere of the scrub-up room.



The West Company has embarked upon intensive research in this field, and the very successful year which the Company has just completed, gives ample indication that the assistance which they have given is valued by the institutions they have serviced.

* * * *

Capital Cubicle Company Folder

The Capital Cubicle Company, Inc., Brooklyn, N.Y., have issued a folder for the purpose of describing the benefits to be derived in using Capital Cubicles for hospital wards and rooms. Illustrations show typical cubicle installations, enlarged view of tubing, fittings and patented curtain hook.

Product description deals with factors of cost, installation, operation and design—contains outline of necessary rough sketch to secure, without charge, plans, specifications and cost.

A copy of this folder will be mailed to hospital executives on application.

* * * *

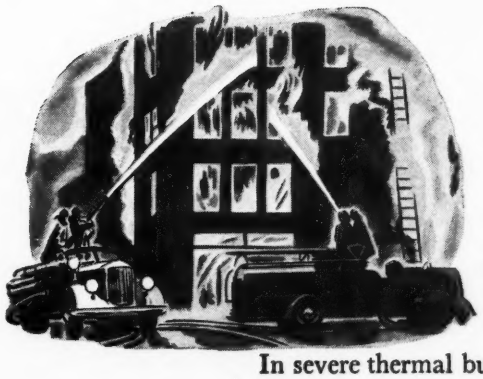
Undertaker to aged mourner at a funeral: "How old are you, sir?"

"I'll be 96 next birthday."

"Hardly worth while going home, is it?"

* * * *

English is the only language that capitalizes "I" in writing. Many languages capitalize "you".



Third Degree

In severe thermal burns, when protein needs far exceed the limits of dietary toleration, Parenamine provides extra-dietary amino acids to restore and maintain positive nitrogen balance and correct hypoproteinemia.*

Parenamine

AMINO ACIDS STEARNS, PARENTERAL

For protein deficiency

PARENAMINE is a sterile 15 per cent solution of amino acids containing all known to be essential for humans, derived by acid hydrolysis from casein, fortified with pure *dl*-tryptophane.

INDICATED in conditions of restricted intake, faulty absorption, increased need or excessive loss of proteins such as in preoperative and postoperative management, extensive burns, delayed healing, gastro-intestinal disorders, fevers, et cetera.

ADMINISTRATION may be intravenous, intrasternal or subcutaneous.

SUPPLIED as 15 per cent sterile solution in 100 cc. rubber-capped bottles.

**Reprints and complete clinical data will gladly be sent on request.*

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NEW YORK KANSAS CITY SAN FRANCISCO DETROIT SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

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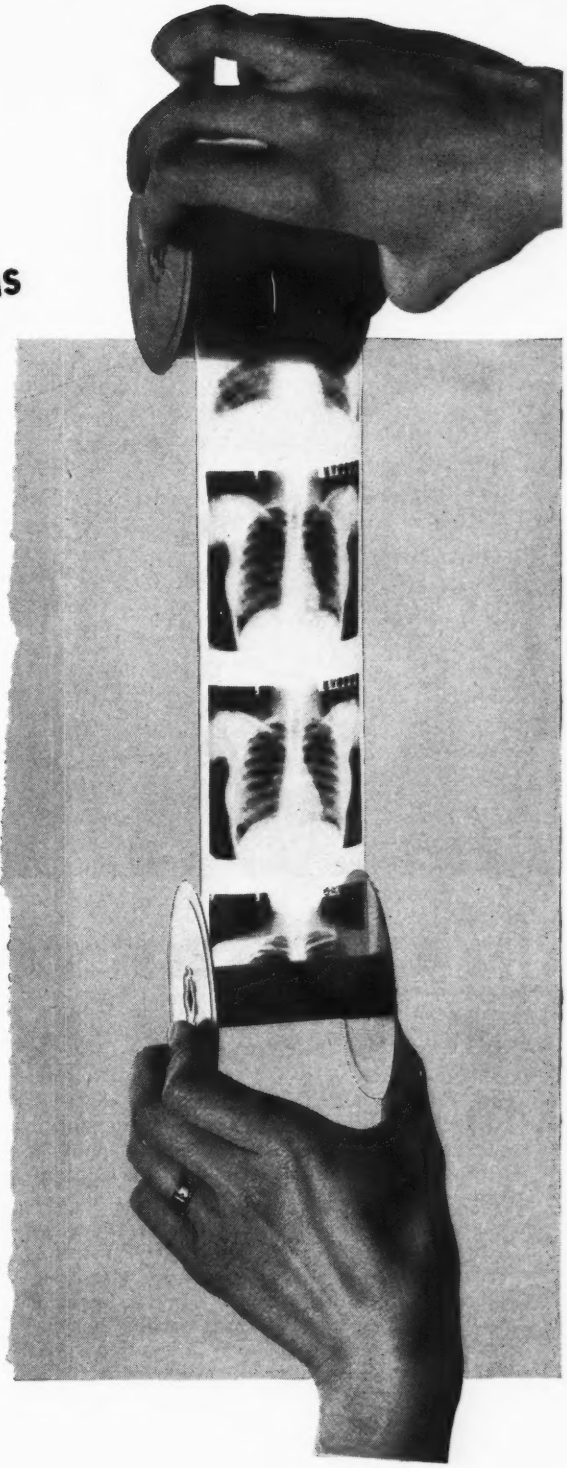
S-86D

use this quick, economical method

to screen hospital admissions

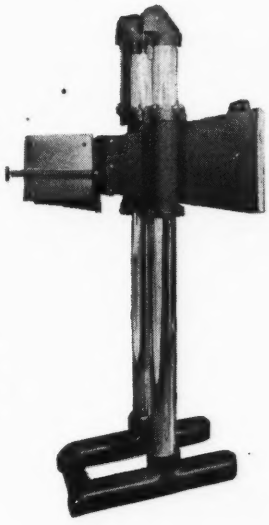


Miniature photofluorography offers hospitals quick, economical help in screening hospital admissions. These routine miniature films enable the radiologist to determine which incoming patients require more thorough chest examinations. Used as a routine hospital admission tool, photofluorography accomplishes three important objectives:

1. Supplies an economical means of determining which admissions require complete chest scrutiny.
2. Recruits patients who might not otherwise receive this examination.
3. Provides accurate telltale signs over and above clinical history and initial physical examinations.

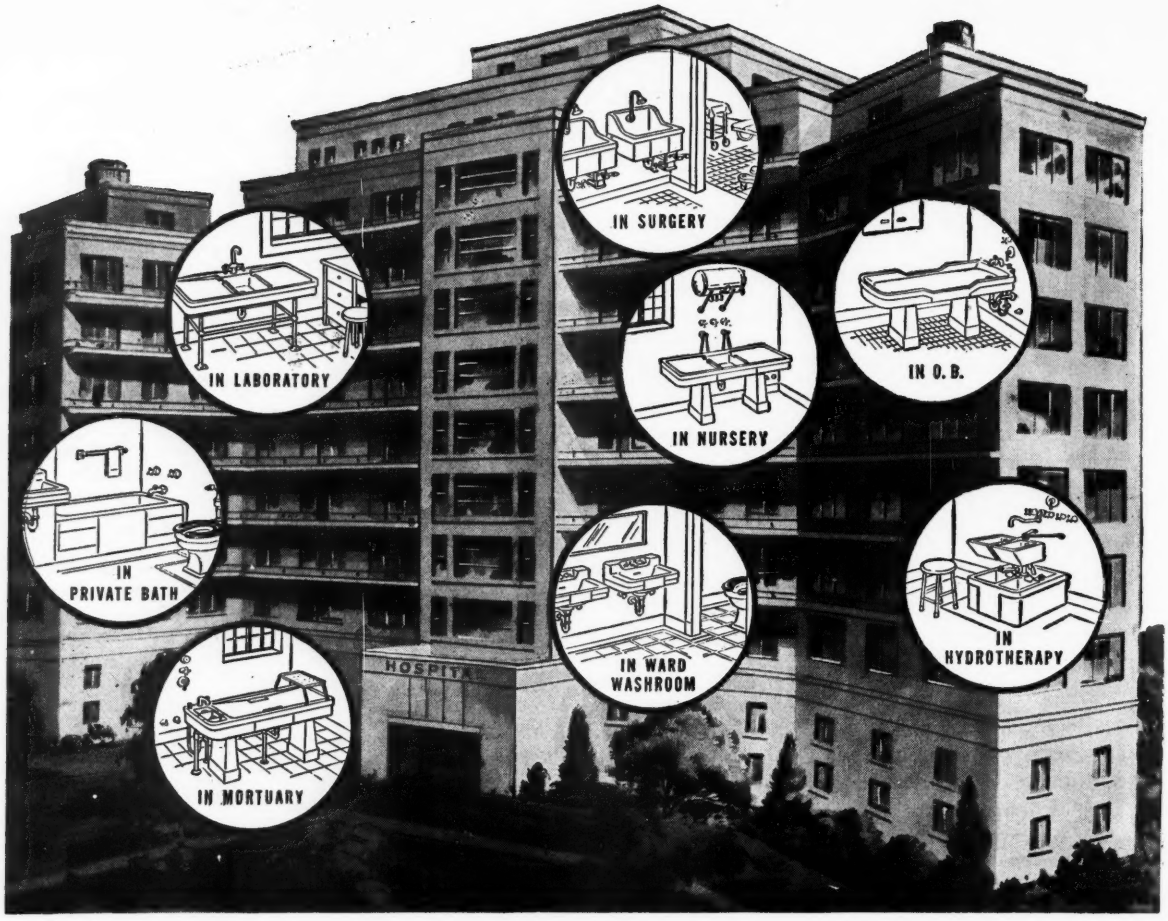
While miniature film methods do not supplant established practices in chest diagnosis, they do perform an important service in augmenting laboratory procedures. Photofluorography need not place heavier loads on the radiological staff. The time needed to read miniatures is minimized, for the chest is either negative or needs standard 14 x 17 radiography for extensive examination.

Write your nearest Ferranti office for complete details on the advantages of miniature photofluorography for hospital admissions.



Westinghouse stationary photofluorograph used in radiographic room and utilizing available generating apparatus.

FERRANTI ELECTRIC LIMITED
X-RAY DIVISION — TORONTO, ONTARIO
HALIFAX • MONTREAL • LONDON • WINNIPEG • EDMONTON • VANCOUVER



CRANE-THE COMPLETE LINE of Quality Hospital Plumbing

● For the hospital work on your boards — whether it be modernization or extension to existing units or new, improved hospitals of tomorrow—specify Crane for every plumbing requirement.

Advances in hospital technique led to the need for highly specialized equipment of every type . . . particularly plumbing. Recognizing this, Crane — in co-operation with famous surgeons and leading hospital administrators—developed a complete line of quality plumbing for every department of the hospital. In this line are fixtures of exclusive Crane Duraclay, vitreous china and porcelain enamel on cast iron—each of which has certain inherent qualities that make it particularly suitable for specific hospital services. The high quality and widespread acceptance of this line are evidenced by the fact that many of the country's leading hospitals are completely equipped with Crane plumbing.

If you do not have a copy of the Crane Hospital Catalogue, write for one. For complete information, consult your plumbing contractor or nearest Crane Branch.

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PUMPS - VALVES
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NATION - WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, April, 1946 Vol. 23 No. 4

Three Related Measures

Free Hospitalization Proposed For All in Saskatchewan

A MEASURE has been introduced by the Saskatchewan Government which would provide hospital care without cost to all residents of the province. This is to be known as the **Saskatchewan Hospitalization Act, 1946.**

This measure as at its second reading would provide every resident in Saskatchewan with public ward hospital care, operating and case room facilities, dressings and drugs, x-ray and laboratory services, anaesthetics, etc.

The Act will be administered by a Commission which shall be responsible to the Minister. Funds shall be raised by the levying and collection of a tax not exceeding $5.00 to be paid by or on behalf of each beneficiary, provided that the levy for any one family does not exceed $30.00 annually. Every resident of the province of 16 years or over and every resident under 16 who is living apart from his parents and is supporting himself shall be personally liable for the tax. Indigents are to be covered and their portion of the tax is to be met by the agency of government, municipal or provincial, responsible for their maintenance.

Hospitals are to be paid from the "Saskatchewan Hospitalization Fund" administered by the Commission. A noteworthy feature is that if at any time this fund is not sufficient to pay all outstanding claims, the Provincial Treasurer shall, without further authority, advance the amount necessary out of the consolidated fund.

Patients electing private or semi-private accommodation may be charged the excess of that rate over the public ward rate by the hospital; with this exception, hospitals shall accept any payment made under this Act as payment in full.

The Commission may make provision for payment for hospital services rendered by hospitals outside the province.

Residents shall be issued a health registration card and patients who claim benefits may be required to submit to examination by a medical practitioner appointed by the Commission. The attending physician shall be required to make such reports as the Commission deems necessary. For these he may be paid. Failure to comply with a request for information may subject the physician to a fine not exceeding $50.00.

Regulations will govern the manner in which payment shall be made to hospitals, the form in which accounts shall be rendered, the kind of information required, the kind of information to be considered confidential and other details.

* * *

Health Services Act

The Health Services Act 1946 is going through the legislature at the same time. This measure permits the division of the province into health regions and paves the way for a broader form of health insurance than that provided by the Saskatchewan Hospitalization Act described above.

This measure provides for the appointment of a medical and sanitary staff for a region, including a medical health officer with assistants, dentists, nurses, sanitary officers and clerical staff.

The members of the public health

staff in each region shall be appointed by the Public Service Commission and shall be under the control and direction of the minister.

The council of each municipality affected shall pay to the Provincial Treasurer each year the sum apportioned by the Local Government Board as the municipality's share of the costs of public health services.

Subject to the approval of the minister a regional board may erect, own, rent or lease, operate and maintain, on behalf of the region, hospitals, health centres, diagnostic and therapeutic clinics and such other property as the board deems necessary for the provision of health services.

The board may make arrangements with hospitals, medical practitioners, dentists, nurses and other personnel to provide health services and may pay for such services.

The board may make such investigations as it deems necessary in order to assess in detail the hospital facilities and health services available in the region and the need for such services and facilities. It may also prepare plans for the improvement of these facilities and services.

Where all or any portion of the estimated expenditure is to be raised by means of a personal tax, the local governing authority shall levy this tax and pay the proceeds over to the regional board.

The council of a municipality may pass a bylaw authorizing the council to provide medical, surgical or hospital care, or any combination thereof, to the residents or to the residents and the non-resident ratepayers of the municipality.

There shall continue to be a commission to be known as the Health Services Planning Commission and the members of the commission shall be appointed by the Lieutenant Governor in Council. The commission will conduct investigations and make recommendations to the minister regarding the provision of health services to any residents of the province, propose boundaries of health regions, recommend training for technical personnel and deal with other matter which the minister may refer to it.

Hospital Standards Act

The *Hospital Standards Act 1946*, has received its third reading in the Saskatchewan Legislature. This Act provides for the approval, classification and grading of hospitals and is obviously designed to supplement the Hospital Services Act, 1946, for the purpose of determining the daily public ward rate to be paid to hospitals.

The Act permits the Lieutenant-Governor-in-Council to make regulations with respect to the use of land for hospitals and the construction, equipment and maintenance of hospitals; the classification and grading of hospitals; the staff and employees of hospitals; the admission, treatment and discharge of patients; the class or classes of patients to be admitted; the classification and length of stay of patients and their discharge; records and reports, equipment, etc. Inspectors may be appointed. The period during which action may be taken against hospitals covered by this Act for the recovery of damages is reduced to three months unless a court extends it to twelve months under certain conditions.

Hospitals Must Co-operate in Future Planning

Hospitals must co-operate in planning their new buildings on a community rather than an individual basis, stated Dr. A. C. Bachmeyer, a director of studies of the Commission on Hospital Care at the February Mid-Year Conference of hospital association officers in Chicago. This Commission, in the work of which a number of organizations are taking part, was set up to determine the need for hospital development throughout the United States.

No hospital should be built without a careful study of the real need of the community. It is much better for the hospitals to do this on a voluntary basis than to have the state step in and do it for them.

Many communities now have large sums of money on hand for construction, stated Dr. Bachmeyer. If these programmes are not coordinated there will be great economic waste, both in the cost of construction and later in the cost of operation. The problems of local ambitions, jealousies, etc., must be overcome. Hospitals should cooperate with the government in working out a solution to this problem. The time is past when hospitals can build without regard to the full interests of the community.

Dr. Bachmeyer did not feel that there was any longer a need for separate hospitals for communicable diseases. These are often empty part of the time and very often the care is poor and haphazard. He recommended that for this purpose a wing of the general hospital be used or that a separate building be erected on the general hospital grounds.

Speaking of convalescents, Dr. Bachmeyer noted that in Great Britain it was found that 30 per cent of the patients in general hospitals could be discharged at almost any time. Convalescence as an entity in treatment is largely a matter of definition. Convalescence can be started in the general hospital. Speaking of tuberculosis sanatoria, he noted that the medical staff were frequently interested primarily in tuberculosis and not so much in the other conditions found. The general hospital has a role in the care of tuberculosis and also, he added, in the care of the mentally deranged.

The Commission, he stated, is giving some thought to the recommendation that hospitals be limited to at least fifty beds or over. If such recommendation be made, scattered and rural areas, unable to maintain a fifty-bed hospital, would need to have provision for obstetrics and minor surgery and other conditions. Some definite control over these smaller units would be needed.

The Admission Office *of an* Outpatient Department

Sr. JEANNE MANCE, Reg.N.
Hotel-Dieu de Montreal.

THE outpatient department of the hospital is an excellent instrument in which the religious, as a faithful follower of Christ, not only practices charity and devotedness but also learns to care efficiently for the patient and gains experience in the vast field of nursing.

Through this department it becomes possible to provide effective treatment for many serious diseases while the patients are still in a curable stage and while they are ambulant. Moreover the outpatient department serves as a valuable field of research and learning to the medical student, the members of the staff and especially the young doctors, calling as it does for continuous investigation of the causes and methods of treating diseases. Hence the hospital with an outpatient department is an important agent in the prevention of disease and the prolongation of human life.

This department must restrict the field of its activities to the patients who are unable to pay even the lowest fees which private physicians charge to their patients. It must wish to co-operate with the medical profession in order to eliminate the use of outpatient clinics by patients who can afford to pay for the services of private physicians. The outpatient department at Firmin Desloge Hospital, where this survey was made, is making a remarkable contribution to the community in providing care for the poor and needy.

Admission of Patients

The Sister Superintendent of the outpatient department of this hospital is directly responsible for admissions to both the O.P.D. and the hospital. She or her assistant receives every new patient for the Clinic. She shows the same courtesy and consideration to everybody. After taking down the name and address, the following questions are put: (1) what is the matter with you? (2) have you been here before? (3) did you see the doctor? (4) who sent you here?

This short investigation will tell her if this patient is eligible or not for admission. There are certain reasons for not accepting a patient at the clinic, such as:

(a) if he has a contagious disease the rule does not permit him to be treated in this clinic;

(b) if he can afford to pay the doctor, he is sent back to him;

(c) if he has been treated in some other clinics and has no suitable reason to give for his change he is required to obtain a letter and a summary of his record if he wishes to receive care in this clinic;

(d) if he has seen his family doctor it is advisable that he see him again and get a letter stating that he really needs care in the clinic.

This investigation seems sound, because accurate records could never be kept if patients come to the clinic one day and go to see the doctor or to another clinic the next day. However, in emergency cases there are no set rules and the clerk is at once called upon to take patients to their respective clinics so as to receive immediate care, while the investigation takes place later. In all these interviews it is important that the patient be encouraged to feel at home and ready to confide all the details of his case.

The social history in the outpatient department does not belong to the sister in charge but to the social workers. The sister superintendent's role is accomplished when it is proven that the patient is eligible for admission. She then checks his name in a book and writes it again on a special sheet to be called for by the social worker.

The social worker, being the one most intimately connected with the patient, is the agent who can best secure his social history. She calls on the patient, makes the social history with additional investigations and classifies him. She then fills in the clinic card, which must be presented at each visit, and gives it to the patient. A charge of 25 cents is made for replacement of this card. Relevant data concerning address, clinic number, etc., are taken to be included on the patient's record.

Before the patient's first interview with the doctor specimens are taken for the laboratory. The attendant takes not only a blood test but also temperature, weight and measure. All new patients pass through the diagnostic admission service and then to the various specialized medical or surgical departments as assigned.

If the patients need care for such diseases as diebetes, heart or genito-urinary, they may come back another day or see the doctor on the same day if it is not too late.

If a doctor gives a patient a prescription, he presents it to the information clerk, who attaches to it a special stamp. One sheet contains three stamps with the same number, a different one for each order for medicine. She attaches the first one to the prescription, the second is attached to the medicine container by the pharmacist and the third is given to the patient who is waiting for his call. She then sends the prescription to the pharmacy by a special dumb-waiter and receives the medicine in the same container.

Admission to Hospital

On admission as an inpatient the social history is taken and the patient classified. There are four definite groups:

1. *Indigent patients:* In this group patients cannot pay anything for their medical or hospital care.
2. *Semi-Indigent patients:* This includes patients who cannot meet the charges of private doctors but are able to pay the clinic registration fee and to contribute in a small way towards their hospital care.
3. *Patients of moderate means:* Includes patients who are able to meet the minimum charges of visits of private doctors but unable to meet full hospital charges.
4. *Private Patients:* In this group, even though patients are able to afford full rates for visits and hospital care, we do not consider them as being exactly private patients, because the rate in this hospital is not high enough to defray the expenses. These patients are admitted to the hospital in emergency cases only.

Patients in the last two classes are not permitted to attend the outpatient department.

Admission of Re-Entering Patients

All patients, whether new or revisiting, make contact with the information clerk. While the routine for the new patients consists only in taking their names and giving them to the sister superintendent of this department, the duties of the clerk regarding the re-visiting patient are much more important.

She writes the date, patient's name, record number and the name of the clinic to which he is to go on a slip for the record clerk. If the patient has been classified as belonging to Group I or II he has nothing to pay; if not he pays 25 cents for his revisits and before leaving pays for his medicines should he have any.

The information clerk writes on a special sheet the record number of the patients who pay 25 cents for their re-visits. She needs these details, plus the money collected for medicines, to check the cash before closing the office.

Records

The record system is so arranged that a patient's record can be removed at any time to accompany him if he is transferred to other departments of the hospital. Similarily, when the patient is able to leave the hospital, his medical record is sent to the outpatient department to be kept in the Record Room.

The sister superintendent of the outpatient department is responsible for all emergency cases. When she cannot attend to them personally, she sends her assistant. In this emergency room she prepares the patient for examination, calls the intern to carry out the routine, take blood pressure, etc., and then the resident doctor to state the preliminary diagnosis.

The sister makes the record, and if, after examination, the patient is to be hospitalized, she makes reservation for a room. When the patient is ambulant she takes him upstairs to the admission office where she writes his social history. If he has been admitted before, she adds any new details which may be valuable. After this investigation she sends the record to the admitting office of the hospital.

Thus a patient is received at this office only after everything has been settled by the sister in charge of the outpatient department, and all that remains is to call a clerk to take the patient to his room. A few exceptions to this rule may occur when they receive patients late in the evening or during the night; in such cases the social history is postponed till the following day.

Since the determination of eligibility for admission requires a study of the patient, it is evident that a knowledge of social service principles and training in social investigation are necessary. In the social service department the director receives private patients for admission when the sister superintendent of the outpatient department is too busy to do it, but both must co-operate in order to further the social welfare of all patients admitted for care. Therefore, the final decision regarding the acceptance of a patient belongs to the sister in charge of the outpatient department or her assistant.

The duties of the director are:

(1) to classify applicants for admission into definite groups.
(2) to reach a decision regarding the disposition of the patient and to direct patients to the proper agencies for professional care.
(3) to supervise the initiation, to control physical care, social and medical records of the patients.
(4) to supervise the adjustment, collection and accounting of registration and other fees paid by patients.

It seems evident that the persons

(Concluded on page 96)

Rev. Hector J. Bertrand, S.J.

Father Hector Bertrand, the new president of the Catholic Hospital Council of Canada, was born in Warren, Ontario. He received his education at Sacred Heart College, Sudbury, graduating with the Bachelor of Arts in 1928, and the same year entered the Society of Jesus. He later taught, both at his own college and at St. Ignatius College, Montreal.

Father Bertrand joined the Canadian Army in 1943 as Chaplain of the paratroopers, and in September of the following year was promoted to the rank of Major and became District Chaplain of Military District No. 10, Winnipeg. He is at present on six months' leave, after which he expects to be discharged from the Army.

Besides his B.A. degree, Father Bertrand also holds the degrees of Ph.D. and D.D. A keen sportsman, he numbers hockey and fishing among his particular enthusiasms.

Before entering the priesthood Major Bertrand had a desire to follow the medical profession; his wishes are now at least partially realized in his new appointment to the Catholic Hospital Council of Canada.

National Health Service Bill for United Kingdom

THE Honourable Aneurin Bevan, Minister of Health, presented to Parliament on March 21 a National Health Service Bill which is regarded as one of the most revolutionary and comprehensive measures of social legislation ever brought before the House of Commons. The Bill is designed to: (a) put free medical care within the reach of all; (b) bring hospitals under state control; (c) prohibit the sale of doctors' practices which are wholly or partly under the National Health Service; (d) provide free spectacles, drugs, dental services and ambulance service to the people. The cost to the Exchequer will be £95,000,000 ($422,750,000) annually and it is hoped that the Bill can be put into force within two years.

This Bill would place the health of the entire population in the hands of the state. Every man, woman and child, from birth to death, will have services of all kinds without any fees or charges. People will be free to choose their own family doctor if he joins the services or if they prefer to pay there will be no ban on private practitioners. They will be able to engage private rooms in hospitals if hospitals are not overcrowded with free patients.

The existing premises and equipment of all voluntary and public hospitals will be transferred to the Ministry of Health. Hospital endowments will not be confiscated by the state but will be placed in a special fund. The Ministry of Health has the duty of providing hospital and consultant services, with the actual administration delegated to regional hospital boards and local management committees. Staffs, including nurses, will be employees of the regional boards. Medical specialists will be attached to the hospital staff but will not be prevented from having private practices as well.

It will be the duty of county and borough councils to provide, equip, staff and maintain health centres, health visitor and home nursing services. Vaccination will no longer be compulsory but free vaccination and diphtheria immunization will be provided for those who desire them. For expectant and nursing mothers and for children under five there will be medical care plus dietary supplements such as cod liver oil and fruit juices. The payment for the latter will be based upon ability to pay.

In connection with the prohibition of the sale of medical practices, the government proposes to recompense doctors who join the services to a total of £66,000,000, any such payment to be made at death or retirement with yearly interest until that time. A medical practices committee will regulate the succession to old practices or the opening of new ones. Doctors taking part in the services will have fixed salaries and per capita fees varying with the number of persons whose care they undertake. The actual sums will be decided upon later. Elaborate arrangements are being made for research and refresher courses for doctors.

This Bill should not be confused with the National Insurance Bill which was placed before Parliament in January, (See page 35).

The Sale of Medical Practices

The medical profession is concerned by the statement in the House of Commons by the Minister of Health, Mr. Bevan, in which he affirms that the government believes it will be incompatible with the provision of an efficient national health service for the future exchange of medical practices and the creation of new practices within that service to be left entirely unregulated. Steps should be taken to secure a proper distribution of doctors to fit the public need. Intervention in this field will probably have the effect of preventing the sale and purchase of practices by doctors taking part in the new service. The government therefore has thought it right to give this warning. But there will be an appropriate measure of compensation to doctors in respect to loss of capital value directly caused by the new arrangement.

The effect of this pronouncement produced an immediate reaction from the British Medical Association. Its secretary, Dr. Charles Hill, who is also secretary of the negotiating committee of the medical profession with the government, states in the *Times* that compensation for loss of capital values incurred by doctors is only just. Capital is represented by the practice which a doctor has paid for or built up, and relies on for his retirement years. When a practice changes hands, what is transferred is good will; the patients themselves are free to accept the incoming doctor or choose another as they please. Many will not share the government's view that an efficient medical service can be secured only by such a fundamental change in the existing arrangements. If the government assumes to direct doctors where and how and with what colleagues they shall practise, the proposal is fraught with danger to the public and to professional freedom. Doctors, like other workers, should be free to choose the form, place and type of work they prefer, without government or other direction. For these reasons the attitude of the medical profession to any proposal to abolish the sale and purchase of practices can be determined only when it is known what is to be substituted for the existing arrangements.

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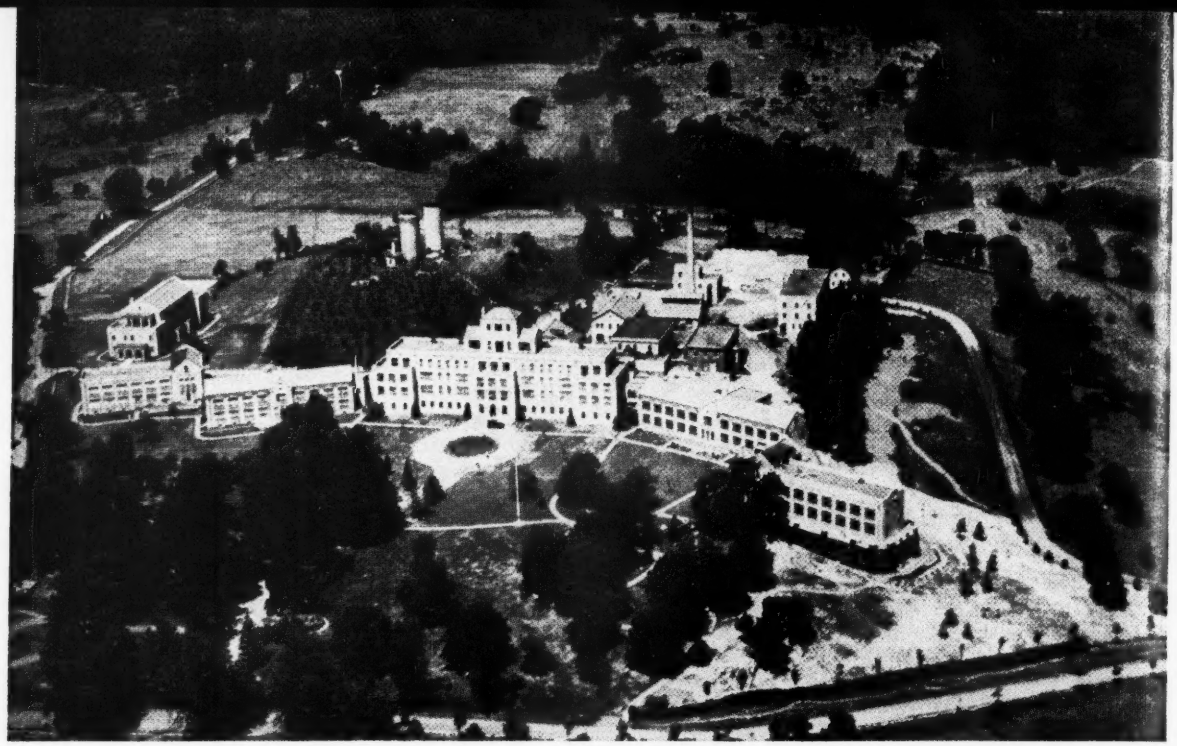


A Study of Five Institutions

Desirable Features in Chronic Disease Hospitals

IN November, 1945, the ratepayers of Winnipeg approved a by-law to build a 200-bed hospital for bedridden, aged persons and other chronic disease patients. With a view to securing the most up-to-date information on this type of hospital, five well-known institutions in the New York area were visited. The institutions and their administrators, all of whom are outstanding authorities in this field, are:

(1) The Montefiore Hospital for Chronic Diseases;
Dr. E. M. Bluestone, Director.

(2) The Montefiore County Sanatorium;
Mr. A. Laskey, Assistant Director.

(3) The Home for Incurables;
Dr. A. P. Merrill, Superintendent.

(4) The Goldwater Memorial Hospital;
Dr. C. G. Scherf, Director.

(5) The Home for Aged and Infirm Hebrews;
Mr. N. Biller, Executive Director.

Three Types

The chronic disease patients under treatment fell into three classes:

(1) Those requiring intensive medical and nursing care for both diagnosis and treatment. This type of patient is often extremely ill.

(2) Those requiring skilled nursing and medical care but relatively little in the way of specialized treatments.

(3) Those who suffer from permanent disabilities and who require considerable assistance and supervision, but relatively little medical and nursing care.

The three types of patients differ widely in their *requirements:*

For the first group, it is essential that a staff of specialists and very extensive facilities for diagnosis and treatment be available at all times.

The second group requires good hospital accommodation, adequate medical attention, and considerable nursing care. It is essential that x-ray, laboratory, and other diagnostic services, and operating room facilities for such emergencies as may arise, be available.

The third group requires what is commonly known as "custodial care". With proper guidance and encouragement these patients can do a great deal for themselves and, although obviously handicapped, they can

By DONALD M. COX,
Secretary and Manager,
Winnipeg Municipal Hospitals.

Above: The extensive grounds at the Montefiore County Sanatorium.

overcome many of their physical disabilities. Some authorities contend that they can best be cared for in a Home for the Infirm adjacent to, and preferably part of, a chronic disease hospital.

Location

Some difference of opinion existed as to whether a chronic disease hospital should constitute part of a general hospital set-up. It was generally agreed, however, that the chronic disease patient (irrespective of age) who requires intensive x-ray, physical therapy and other hospital facilities involving a very heavy capital outlay and the services of a large staff of specialists and technicians could be most suitably and economically treated at a general hospital, where the necessary equipment and staff of specialists are available.

On the other hand, an institution for long-term, chronically ill patients should, if at all possible, have more extensive grounds than are economically feasible at a general hospital or a medical centre. If the distance is not too great, and transportation facilities are good, there are definite arguments in favour of such an institution being located where ample ground space is available, provided the patients to be cared for do not normally require the intensive treatments previously referred to and arrangements can be made to transfer to a general hospital those who develop a need for such treatments.

Above: Chronic patients have time to develop latent talents.

Left: Good use is made of the library.

All the directors held very definitely to the contention that no case is entirely hopeless. Great emphasis was placed on the necessity of encouraging chronic disease patients to do as much as possible for themselves rather than permitting them to degenerate into complete helplessness. For this reason, the greatest possible use was made of wheelchairs. Wash basins and mirrors were conveniently placed and toilets were fitted with wide doors and handrails to enable patients in wheelchairs to attend to their own needs. Dining rooms with special tables were designed to accommodate wheelchair patients.

Occupational Therapy

The chronic disease patient requires the mental and physical stimulus of occupational therapy. The New York institutions had very well-organized occupational therapy departments with a wide range of work projects under the direction of skilled supervisors. They all stressed the danger of patients undertaking work for which they were not physically, or mentally, suited and which might prove harmful to them. For this reason, the scope of the patient's occupational program was prescribed by the attending physician and was subject to periodic review. Complete records were kept. The occupational projects were classified as "Diversional" and "Functional" and each

The sunny Roof Garden is much appreciated.

of these was again broken down into "ward" and "shop" groups with the result that the ambulant, or wheelchair, patient could be assigned to either diversional, or functional, work in the workshop, and the bed-patient also could be assigned either diversional or functional projects.

Every effort was made to ensure the patient's *comfort* and contentment. Auditoriums or assembly halls were provided. Motion pictures and concerts were held at regular intervals, and on certain occasions the patients themselves arranged very fine programs from among their own group. In several instances, *chapels* were provided for religious services; while in others, these services were held in the auditorium. Pay telephones were conveniently located for use of both wheelchair and ambulant patients.

For safety reasons, *smoking* in bed was very generally discouraged. Small smoking-rooms and sitting-rooms were conveniently located and patients who wished to smoke were encouraged to make the greatest possible use of them.

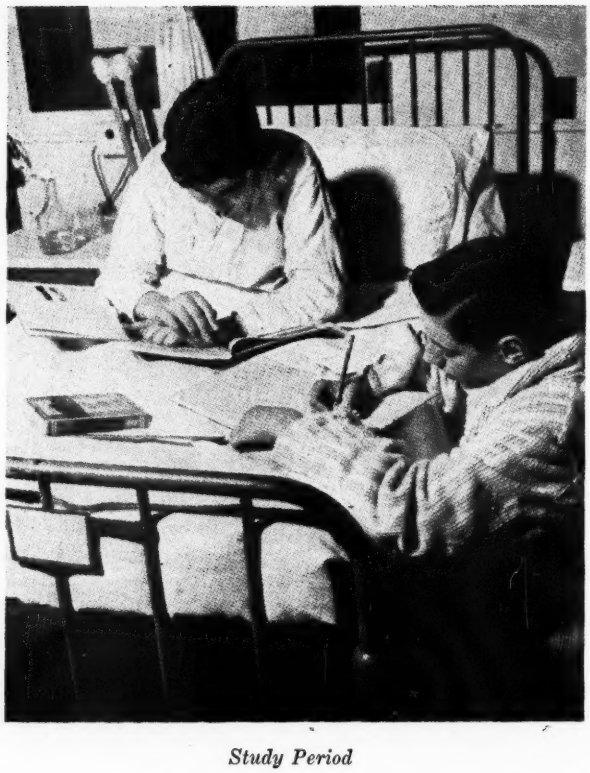
Very well-equipped patient *libraries* were maintained with reading-rooms, and a regular bedside service by means of bookcarts, was available for those unable to visit the library. Considerable care was taken to guide and assist patients in their choice of literature and to inspire a desire for reading in those who had formerly taken no interest in books.

Patients' Quarters

As regards the physical aspects of the institutions visited, the ward and corridor doors were wide, and windows were low to afford bed-patients a view of the hospital grounds. Handrails were installed along corridors used by patients. Wherever possible, outside doors used by patients were on sidewalk level. Different types of patent flooring were used to minimize the danger of patients slipping. Additional elevator service was provided to accommodate the large number of wheelchairs. In some instances, wheelchair rooms were located on each ward; while in others, the corridors were made sufficiently wide to leave room for parking the chairs. Various patented windows were used but it was the general opinion that the conventional window was the most satisfactory.

Although some institutions had dormitory-type wards, it was a unanimous opinion that the most suitable sizes were one-, two-, and four-bed wards; and that wards larger than six beds were decidedly unsatisfactory. Nursing stations, service-rooms, and diet kitchens were not materially different from those found in a modern sanatorium.

The wards and lounge-rooms were bright and cheerful. The furniture and decorations presented a pleasing colour scheme, and the typical institutional atmosphere was noticeably lacking.



Study Period

The inspection of the New York institutions prove to be both an inspiration and a challenge. One could not study their buildings and equipment, look over their records, visit their wards, and talk with the patients, without realizing that the directors were very definitely committed to a policy of providing the utmost in scientific care. Obviously they had constantly in mind that very apt description of a good hospital as "a place where science and mercy meet."

Vitamin Regulations Announced

Changes in the regulations covering the labelling and advertising of products containing vitamins have been announced by the Hon. Brooke Claxton, Minister of National Health and Welfare.

Under the new regulations, which amend those issued last October, a food may be advertised as "a good dietary source" of Vitamin D if the food, when ordinarily prepared as directed on the label, contributes not less than 160 International Units of Vitamin D in a reasonable daily intake.

To avoid the necessity of biological assays, the Vitamin E content of products is to be shown in milligrams instead of in International Units and stated in terms of alphatocopherol. If foods to which any vitamin or vitamin concentrate has been added are packaged in unit containers of less than 100 grams or 100 millitres, the vitamin content is to be stated per package.

The amended regulations also provide that the vitamin content of drugs and dietary supplements (except those dispensed in capsules, tablets, etc.), must be stated per gram for solids and per millilitre for liquids.

Hospitals of Yesteryear

In Lighter Vein

By HARVEY AGNEW, M.D.

A GLANCE at the long record of hospitals through the clarifying crystal of history does not always reveal the same picture. Usually our impression is of a long succession of devoted men and women who have consecrated and sacrificed their lives for the stricken; at other times we may only see "pest houses" of gloom and despair, of odours and contagion, and of desperate and futile refuge in the grim race against the henchmen of Death. Or on occasion, as today, it may please us to see the lighter side of life as it was experienced in "ye ancient spytals."

The Medieval Hospital

The medieval hospital was as different from the highly efficient scientific institution of today as the ox-cart from today's transoceanic airliner. Scientific medicine, of course, was quite unknown. Did not Paracelsus write that the four pillars of medicine were philosophy, astrology, alchemy and the virtue of the physician—but that the greatest of these was astrology? Moreover it was long held that illness was the result of sin. As the Bishop of Bristol wrote, "It (the medieval hospital) was primarily an ecclesiastical, not a medical institution. It was for care rather than for cure—for the relief of the body when possible, but, pre-eminently, for the refreshment of the soul". The early monastic hospitals were known as "bede houses" because the patients depended upon prayer and spiritual purification for their recovery and were expected, also to pray for the souls of their benefactors. In Genoa the more generous contributors were honoured by statues in the hospital; if they gave a hundred thousand crowns or over, they were entitled to a seated statue!

This linking of sin with disease may have been a factor in the not uncommon flogging of patients, particularly if they had had the indiscretion to contract venereal disease. That might be an idea (though perhaps not such a good one) for the present anti-venereal campaign.

Early records would indicate that the hospital of those days was far from being "the doctors' workshop" as it so aptly called today. Karl Sudhoff of Leipzig writing in *Nosokomeion* reminds us that the records of the early hospitals in Rome, Ostia, Lyons, Paris, Milan, Arles, Poitiers, Rheims, Tours and Strasbourg during the 6th to 8th century made no mention of medical services or attendants. One exception was the hospital in the Spanish city of Menida, founded in 573, which followed the Byzantic influence and had nurses, physicians and an ambulance.

The Monastic Hospitals

The monastic hospitals of England which preceded the Reformation were subject to rigid discipline. A life of poverty, chastisty and obedience was the triple vow usually required of both staff and head. The Warden, according to Rotha Mary Clay, had to "sleep in" every night, never to be absent for long, or, in some cases, go more than a mile or two away; in other instances, he was forbidden to frequent the ale house, to take part in hunting or "inhonest plays," or even to indulge in such innocent amusements as dice, cards or handball. Present day administrators, however, may envy the right of the wardens of those days to enforce discipline or settle staff discord by a stiff application of the rod.

The reasons underlying the tragic destruction of the monastic hospitals by Henry VIII need not be elaborated here. It was unfortunate that the King's quarrel with the Papacy had to involve the hospitals whose many services to the nation were only appreciated after they had been destroyed. From an impartial viewpoint, however, it would seem that the monastic hospitals did help to bring this action on their own heads by permitting the extensive use of their facilities by travellers to the exclusions of patients, by housing pensioners at the request of nobles and by spending large sums on relics, often said to be of dubious authenticity, rather than upon needed equipment. Certainly the fine Sisters' hospitals of today, with their unexcelled equipment and meeting every standard, are a far cry from the monastic hospitals of the XVth and XVIth centuries.

Be all that as it may, the next two hundred years of hospital history in England formed a much darker page. But more about that later.

Thomas Gale, the military surgeon, railed mightily against the witchcraft of his day. To quote him from H. A. J. Lamb's *Diary of Yesterday*, "In the year 1562 I did see in the two hospitals of London, St. Thomas's and St. Bartholomew's, to the number of CCC and odd, poor people that were diseased of sore legs, sore arms, feet and hands, with other parts of the body so sore infected, that a hundred and twenty of them could never be recovered without loss of a limb. Or they were either maimed, or else undone for ever. *All these were brought to this mischief by witches,* or by wandering dirty fellows."

Reprinted by permission from the 1945 Anniversary Number of the "Historical Bulletin" of the Calgary Associate Clinic.

Much of our knowledge of European hospitals in the latter part of the eighteenth century, we owe to John Howard, "a respectable English gentleman of forty-seven years," who during the period 1773 to 1790 became the best informed man of his time on English and continental hospitals by virtue of his passion for visiting hospitals wherever he travelled. Two books record his findings. Howard did not hesitate to be critical. Of the food service at the famed Hôpital de St. Jean de Jerusalem in Malta he wrote, "The patients were served by the most dirty, ragged, unfeeling and inhuman persons I ever saw." The patients, between five hundred and six hundred in number, and arranged in four rows of beds, had but twenty-two servants, many of them debtors or criminals; the twenty-six horses with a like number of mules in the Grand Master's stables had forty attendants!

This observer liked the Paris hospitals least of all, especially in comparison with Spanish and Italian hospitals, but he did not spare the hospitals of his own country. He quoted the regulations deemed necessary in the Royal Hospital at Haslar in Hampshire. For instance:

"Ordered,

"That no dirt, bones or rags be thrown out of any window, or down the bogs . . .

"That no nurse or other person do wash in the water closets . . .

"That all nurses who disobey the matron's orders, get drunk, neglect their patients, quarrel or fight with any other nurses, or quarrel with the men . . . be immediately discharged . . ."

As for the London hospitals, he found that "white-washing the wards is seldom or never practised; and injurious prejudices against washing floors, and admitting fresh air, are suffered to operate." He adds, "Bathing, hot or cold, is scarcely ever used; I suppose, because it would give trouble to the attendants."*

The Grand Lits of Paris

Mention of Paris hospitals recalls Tenon's *Memories of the Hospitals of Paris,* published in 1788. The old Hôtel Dieu boasted some 1,220 beds, most of which "contained" from four to six patients! To be more exact, the more active, irrespective of sex, occupied the beds, the *grand lits,* and those less (or more) fortunate draped themselves on the straw around it. Not having a modern call system it was not uncommon to have someone in the centre of the bed become very cold before being removed. Tenon held—and we think with reasonable justification — that not more than four persons should occupy a bed of fifty-two inches in width. With rare wisdom he observed that to allot a person less than thirteen inches would result in unnecessary squeezing.

To put more than one patient in the same bed was a common procedure of those days. Howard also noted it in his wanderings and, as an exception to a prevailing custom, wrote of a Stockholm hospital that "a distinct bed was alloted to each patient, and all was clean and neat." In writing of the Hôtel Dieu in Paris, Haggard notes that there were *eight* beds for children, these beds accommodating (?) a total of 200 infants and young children† However, it may be a surprise to some to know that up to a few years before the present War, a large hospital in a southern city of the United States frequently admitted two patients to one bed.

As for diet, the records would suggest that in some of the early hospitals at least the patients fared very well although without the scientifically balanced diets of today. In the monastic hospitals of England we read of patients getting a gallon of beer (daily we presume) a daily loaf of bread, meat three days a week (eggs on the other days), herring, cheese, butter and vegetables. Extra fare was provided on the numerous festival and feast days. In some hospitals, however, the fare was far from satisfactory.

Alcohol was long a staple in the days when permits and coupons were even beyond the imagination of a Jules Verne. Its ubiquitous use became such a curse that finally, in 1873, a Temperance Hospital was founded on Hampstead Road. At that time the workhouses alone were spending £80,000 a year on alcohol. However, the experiment to substitute milk for alcohol was a risky one in view of public opinion. To illustrate the comment of a leading medical journal was, "God help the patients!" *The Times,* too, warned the founders that coroners and juries would deal with them if any lives were lost in this foolish experiment.

The Early Nurses

Nurses, it would seem, were part of the hospital picture long before the doctors. The records would indicate, too, that nurses were utilized long before the Christian era. Women have always cared for the sick! Hygeia was a goddess, not a god. The pagan priestesses were more personal than the priests in their ministrations, and Rome had its Vestal Virgins.

Some of the early nurses were given wide powers. For instance in the third century B.C., nurses in India were given certain standards by King Asokas: "The nurse must know how to compound drugs, must be clever, devoted to the patient and pure in body and mind; skilled in every service that the patient may require, endowed with general cleverness, competent to cook food, skilled in bathing and washing the patient, well conversed with rubbing or massaging the limbs, lifting the patient or assisting him to walk about, well skilled in making and cleaning beds, ready, patient and skilful in waiting upon one who is ailing, never unwilling to do anything that may be ordered." With the exception of requiring a nurse to

*Ransom, J. E., "John Howard on Hospitals," *Hospitals,* July '36.

†Haggard, H. W., *Devils, Drugs and Doctors.*

compound drugs, this would be a fair goal for any nurse of today.

However, nurses in the thirteenth century were very human and apparently somewhat of a problem. Mondeville, the great French surgeon, wrote: "The surgeon, therefore, must be careful in the selection of his nurses, for some of them obey very well, while he is present, but do as they like and often just exactly the opposite of what he has directed when he is away."

It was in the period after the destruction of the monastic hospitals and during the early period of the "Royal Hospitals" which preceded the voluntary hospital movement that hospital nursing became a tribulation and a trial to both patient and administrator alike. Seneca said that "light troubles speak; immense troubles are silent"—but some of these troubles were neither light nor silent. Although there were examples of devotion and loyalty beyond measure, nursing at that time fell to a low ebb. Evans and Redmond Howard* contrast the medieval hospital of the days of the Crusades with those of England "from the days of Hogarth and the 'Beggar's Opera,' to those of Dickens' day and the Fleet Prison." Nurses in the early days of the London Hospital "were invariably recruited from the ranks of broken-down widows, and referred to by their second name, apparently to avoid enquiries as to whether 'Mrs.' or 'Miss'." Night nurses, called "watches," received three shillings and sixpence a week. To quote Morris who had to chastise them, "all belonged to the honourable society of topers." The head-nurse, or matron, he stated, was generally the wife of the hall-porter and he quotes Sir Henry Burdett, who wrote the *History of the London Hospital*, "every vice was rampant among these women whose only aid to the dying was to remove pillows and bed clothes and so hasten the end."

Sarah Gamp Nurses

The Sarah Gamp period, immortalized by Dickens, elicited many scathing and time-resistant comments from exasperated doctors and hospital governors. One English physician of the early Victorian period is quoted as remarking, "We always engage nurses without a character, because no respectable woman will take such work."* Evans and Howard also quote pre-Victorian hospital rules formally forbidding these so-called "nurses" to "fight, blaspheme or get drunk." Perhaps the low rate of pay in hospitals, always a problem, may have been a factor, for, as Sir Henry Burdett noted, "The most that could be hoped for, at six shillings a week, was that they were neither Irish nor confirmed drunkards."

At Guy's, a hundred years ago, the nurses were ordered to "wash all weak people's clouts without taking money or reward for the same."

Some years ago we were shown an old order at this hospital which we hope was not destroyed by the Germans: "She (the charge nurse) shall accompany the Butler upon the ringing of the Beer Bell and shall take with her such Patients as are capable of carrying the Beer to the Wards" and here was added a caution undoubtedly born of sad experience "and shall not suffer such patients as carry the Beer to embezzle it by the Way."

* * * *

Finally, we may recall the serious controversy about the end of World War I as to whether nurses (pupil nurses only, of course) should be permitted to "bob" their hair. Some superintendents of nurses even stated, and with considerable emphasis, that no bobbed-haired hussy would ever be admitted to their training school! Why, the girl who would bob her hair might even smoke! Well, times have changed and now the girl with a "bun" seems to be the oddity. The issue might have been settled more quickly at that time if proponents of this radical departure from accepted custom had invoked the weighty support of tradition by quoting an old order at Chichester that "the males be cropped below the ear, and the hair of the women be cut off back to the middle of the neck."

**The Romance of the British Voluntary Hospital Movement.*
*Evans and Howard.

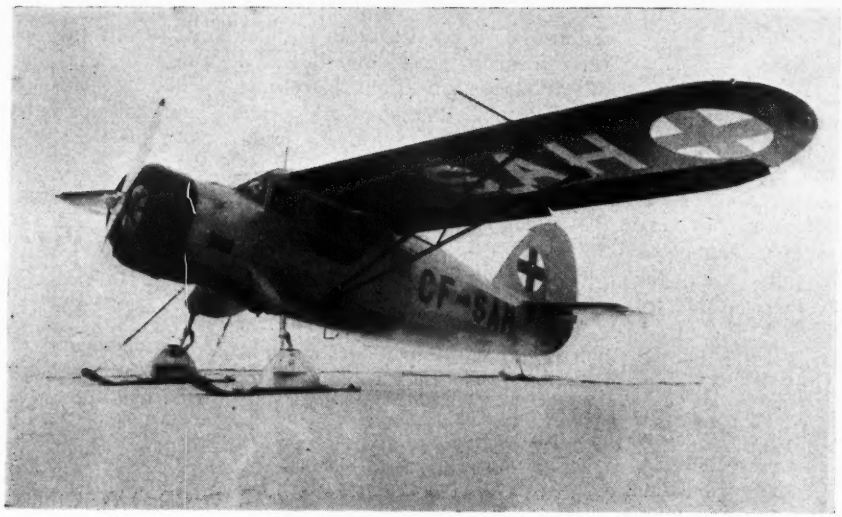
British National Insurance Bill

The National Insurance Bill providing for increased illness, unemployment and retirement benefits at an estimated cost in the first years of £452,000,000 was laid before Parliament on January 24. Described by government spokesmen as the "best bargain in the world", Labor's version of the Beveridge Plan will provide a wide range of benefits in exchange for a contribution from the employed man of four shillings and seven pence (about ninety-two cents) a week.

The bill contains seventy-nine clauses and eleven schedules, but from the individual's point of view the operation will be simple as he will have only one card, one contribution, and one record covering sickness, unemployment, retirement benefits (a new phrase for old age pensions) maternity and family allowances, and death benefits. Family allowances of 5 shillings a week for each child after the first are scheduled to begin on August 6, and most of the rest of the plan is to be operative by next fall.

Sickness insurance, as stated in the *New York Times*, is the most liberalized of the benefits, all of which would be increased above present levels. A man, wife and child now able to draw 18 shillings sickness benefits would receive nearly 50 shillings a week under the new bill. The bill proposes the establishment of local tribunals to pass on applications for unemployment insurance but no "means test" may be applied and they will have no power to vary the rate of benefits, as in the past . . . Preliminary reaction in the lobbies of the House of Commons indicated that this bill would meet light opposition.

Reprinted by "Public Health Economics" from the "New York Times".



Motor Ambulance for Mental Patients

Saskatchewan Government Provides Flying Ambulance

By CHRISTIAN SMITH,
Director of Health Education, Saskatchewan Dept. of Health

AIRPLANES are no novelty in most of Saskatchewan, but when farmers and villagers hear the deep-toned roar of a motor and see a yellow and green aircraft streaking through the sub-zero air, they say feelingly, "There's the flying ambulance again. Wonder where it's headin'."

Saskatchewan's new flying ambulance service which whisks emergency patients from snowbound hamlets and isolated farmsteads to city hospitals and medical care has proved immensely popular as well as a real life-saver.

Since the service was inaugurated on a cold Sunday following a typical western blizzard, the aircraft has made more than daily flights, chalking up 20 trips in the first 16 days. The blizzards block highways and make light of train schedules, but if the air ambulance can get off the ground at Regina, and if it's in daylight hours, service gets through to the people who are in need of immediate attention.

The Department of Public Health acquired a Norseman craft powered with a 600 h.p. Wasp engine and a cruising range of 500 miles to serve all of Saskatchewan south of Prince Albert. From Prince Albert north ambulance service is provided by a plane of the Department of Natural Resources.

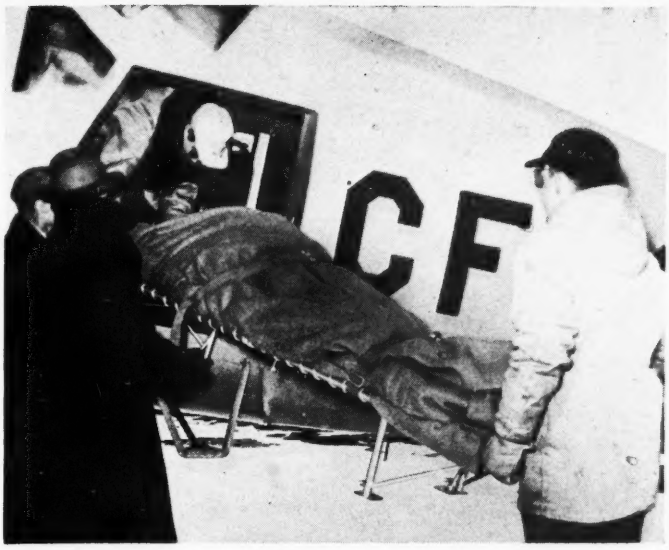
The Health department provides a swift transportation service only. It is up to the people who request the service to arrange for hospitalization and medical care at the centre where the patient is being taken. The Provincial Government charges a flat rate of $25.00 per flight, without regard to distance or hazards, provided it is an actual emergency. If it is shown not to have been an emergency, actual cost of the flight is charged.

The Norseman craft is specially fitted for ambulance work and can carry four persons in addition to the standard crew of three. On every flight the pilot is accompanied by a flight engineer and a nurse. Pilot Keith Malcolm and Engineer Donald Watson are both former R.C.A.F. men, and Nurse M. E. Gleadow served overseas with the Royal Canadian Army Medical Corps.

The first patient carried by the air ambulance died shortly afterward in a Regina hospital, but the whole crew has been calling on patient No. 2. Alma Everett, 20, of Liberty, Saskatchewan, who suffered from an acute blood condition.

"The air ambulance saved my life. I'm sure of that," Miss Everett told her visitors. "When I am discharged from the hospital I want to see the plane." She was unconscious when brought to hospital in Regina and knows nothing of her first air-plane ride.

The first case, the fatal one, was a diabetic. And since Miss Everett's trip there have been many others for



Loading a critically ill patient within a short distance of her snowbound farm home.

a variety of emergencies—a boy with an acute condition following an appendectomy, several middle-aged people with heart conditions, a young woman with critical abdominal trouble, and so on.

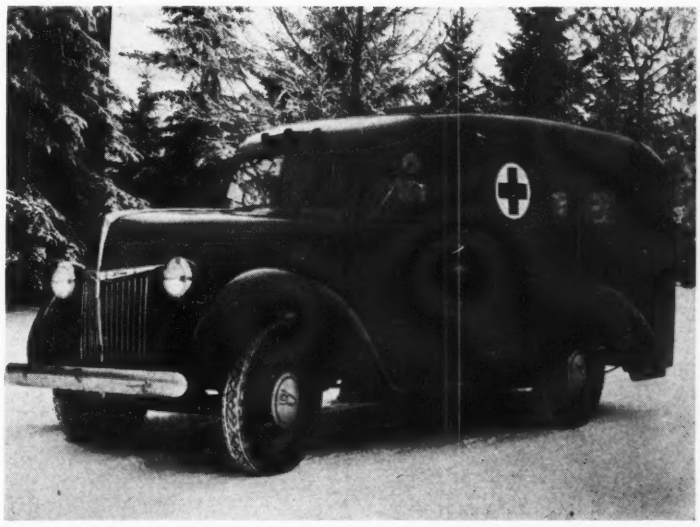
The crew of the flying ambulance love their jobs although it is more hazardous than ordinary flying. Malcolm usually has to put the craft down in unprepared places—stubble fields, pastures, etc.—where hidden stones or bumps menace landings. In some places he has made as many as seven landing attempts before finally putting the ambulance down. But he does get her into otherwise unaccessible spots, sometimes as close as fifty yards from a patient's farm house.

All landings with patients aboard are made at prepared airfields. Since the ambulance is equipped with two-way radio, communication with airports is maintained throughout most trips.

Provincial Ambulance Service

The Saskatchewan Department of Public Health has also bought three former R.C.A.F. motor ambulances for the transportation of mental patients. This provides privacy for cases formerly conveyed by train or public bus.

New regulations governing ambulance services in Saskatchewan have been passed by order-in-council. Ambulances now have to carry specified first aid kits, which must be under direct charge of a person holding a senior first-aid certificate, must pass the prescribed examinations of the St. John Ambulance Association every year.



One of the Motor Ambulances.

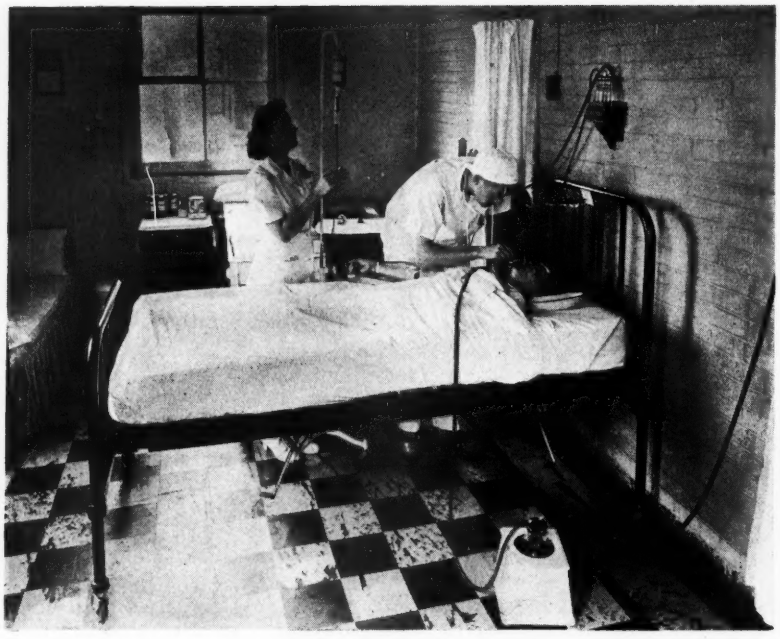
Albert George Nicholls

Dr. Albert George Nicholls, M.A., M.D.C.M., D.Sc., F.R.S.C., F.R.C.P. (Can.) died at his home in Montreal, 2174 Sherbrooke Street West, on March 3rd in his 76th year. Dr. Nicholls was widely known throughout America as a teacher of pathology and bacteriology and had held chairs both in Dalhousie and in McGill. Dr. Nicholls had been a frequent contributor to scientific journals and for many years prior to the recent war was Editor of the Canadian Medical Association Journal. In recent years, with failing health, he had been Editor Emeritus. A scholarly man, he had done much to maintain the high scientific quality of the magazine.

Dr. Nicholls is mourned by his widow and three sons.

Plans Rehabilitation of Hospitals in China

The United Church is sending Dr. A. Stewart Allen, Montreal, to China for two months to investigate rehabilitation of Canadian mission hospitals. He will also look into the possible development of schools for the training of Chinese nurses. Dr. Allen was chairman of the Chungking committees of Canadian War Relief which handled Canadian Red Cross contributions to China.



A Post-Operative Recovery Room *and Blood Bank*

HAROLD GRIFFITH, M.D.,
Medical Superintendent, and
MABEL MacMILLAN, Reg.N.,
Homeopathic Hospital of Montreal.

THE need for a specially equipped room for the immediate care of post-operative patients has long been recognized by anaesthetists and nurses, but no one did much about it. In 1943, J. S. Lundy reported how the problem had been solved at the Mayo Clinic. Following this example we decided to attempt an adaptation of the same plan for the Homoeopathic Hospital of Montreal, a general hospital of 120 beds. We felt that we could combine the separate activities of a Recovery Room and a Blood Bank, and thus make it economically feasible to employ, as full time technical supervisor, a specially trained and highly qualified graduate nurse. The problem of space and location for the room was next approached. We felt that the room should have accommodation for as many beds as we had operating rooms (in our case, two) with additional space for a blood donor table and recovery couch and that it should be near the operating rooms. We decided to use a sun porch on the same floor as the operating rooms, which was then partly enclosed by glass windows, but which might be made into a fairly comfortable ward. For funds we approached the Women's Auxiliary of the hospital, which became enthusiastic about the plan and generously contributed $2,000.00. This money was spent on insulation of the walls and roof, installation of running water, electrical alterations, asphalt tile flooring, and special equipment, and adequately covered the initial cost. In the meantime we had chosen Miss Mabel MacMillan, one of our recent graduates, as nurse in charge. She was sent for several weeks of special training in blood bank technique to the Royal Victoria Hospital, Montreal, where Mr. G. J. Van Dorsser very kindly initiated her into the secrets of his most excellent department.

The equipment assembled may be listed as follows:

Recovery Room

1. Suction (in our case by water) with fenestrated catheters for removing mucus, blood, etc.

2.—Oxygen—a large cylinder with reducing valves and flow meters stands at the head of each bed. Oxygen is usually administered by nasopharyngeal catheter, but BLB masks and breathing bags are also available.

3. Laryngoscope, endotracheal

Above—Part of Post-Operative Recovery Room, showing patient in her own bed, oxygen by nasal catheter, suction for mucus, and the administration of blood.

Cabinet in Recovery Room
with instantly available oxygen mask, airways, laryngoscope, endotracheal tubes, hypodermic syringes, analeptics, sedatives, etc.

tubes, pharyngeal airways, mouth-gags, tongue forceps, etc.

4. Hypodermic and intravenous needles and syringes of various sizes, kept sterile and ready for instant use.

5. Hypnotic and analeptic drugs; such as morphine in ampoules for intravenous or hypodermic use, coramine, epinephrin, ephedrin, etc.

6. Sterile intravenous trays and various solutions for intravenous therapy (Baxter).

7. Sphygmomanometer and stethoscope.

8. Arm boards and restraining straps.

9. Electric bakers, extra blankets, etc.

10. Instrument cabinet, tables and chairs, and adequate cupboard space.

11. Movable curtains to screen the patients when necessary.

Blood Bank

1. 12 Baxter donor sets.

2. 12 Baxter recipient sets.

3. An adequate supply of vacuum bottles for collecting and storing blood.

4. Needles and bottles for blood plasma.

5. Electric refrigerator.

6. Microscope and other equipment for blood grouping and cross-matching.

7. A sink with special nozzles for thorough rinsing (see cut) of blood transfusion equipment and chemical cleaning agents.

8. A table, with built-in arm boards, for the donor to lie on when giving blood, and a comfortable recovery couch.

The Post-operative Recovery Room, or "P.O.R.R." as it soon became called, was opened on December 1, 1943. During the more than two years since then it has developed into such a valuable department of the hospital that we now wonder how we ever got along without it. Almost all the patients operated upon in the main operating rooms of the hospital are taken to the "P.O.R.R." for a period of time varying from a few minutes to several hours. They go there in their own beds, and remain as long as the constant attention of a nurse is necessary. The following statistics reveal the amount of work done:

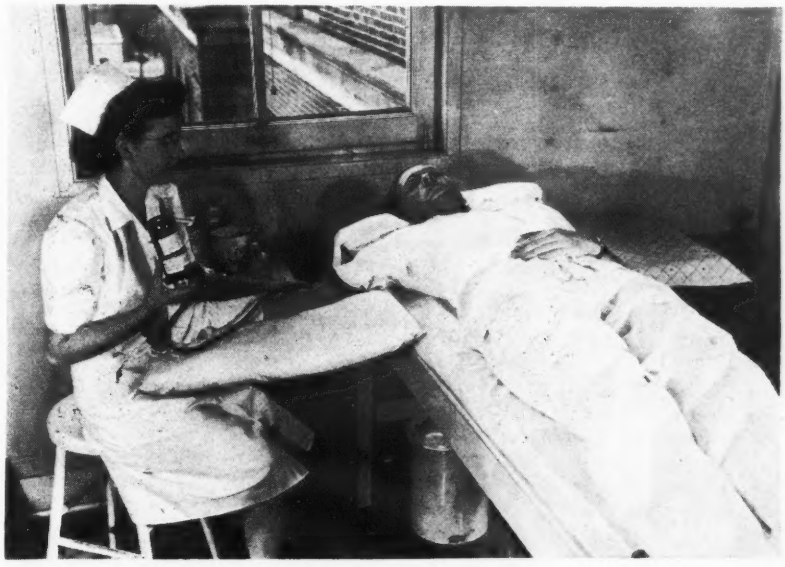
	1944	*1945*
Total operations ..	1860	1920
Patients cared for in "P.O.R.R." ..	1306	1448
Blood Transfusions	376	439
Blood Donors	436	528

The *advantages* of the "P.O.R.R." may be listed as follows:

1. Patients receive expert and immediate care during the critical period of recovery from anaesthesia and operation.

2. All emergency equipment is available and kept in good condition.

3. Floor nurses are saved time and worry, since the patients are not returned to the wards until they are



The Blood Donor Table

Refrigerator in Blood Bank
showing available blood and plasma. Plasma is made from over-age blood by syphoning technique.

conscious and in fairly good condition.

4. Student nurses are given supervised instruction in the immediate post-operative care of patients.

5. Blood transfusion service is greatly improved, since one experienced person is responsible for the collection and administration of blood and the care and cleaning of equipment. Reaction rate in 1945 was under 5 per cent and there has been no serious reaction.

6. 'P.O.R.R." may be used as an emergency ward for the treatment of shock or unconsciousness from any cause.

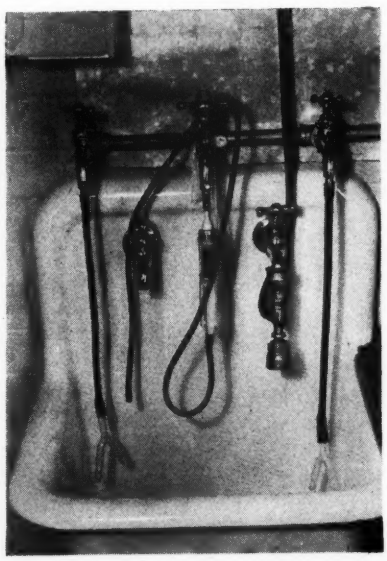
Comments

Experience has taught the value of the following points:

1. The Recovery Room and Blood Bank is under the medical supervision of the chief of the Department of Anaesthesia. We believe that, in a well-organized modern hospital, anaesthesiology should include oxygen therapy, blood transfusion and other parenteral fluid service, and shock therapy.

2. The Recovery Room should be located as close to the operating room as is practicable, in order to minimize the time taken to transport patients and to be within easy reach of the anaesthetists.

3. Space for one bed for each active operating room has proved ample, provided the patients are returned to their own wards as soon as the period of unconsciousness or depression is over. The average length of stay of patients in our "P.O.R.R." is less than one hour. Some have advocated a recovery room to care for patients for a period of 24 hours post-operatively. This would require more space and more nurses, and in our opinion is not necessary in a general hospital.



Cleaning Transfusion Equipment
Sink has special faucets arranged for prolonged rinsing. Water suction apparatus also shown.

4. There has been no difficulty about using the room at the same time for patients of both sexes, and for private and public patients. Movable curtains on overhead wires provide all the privacy that is necessary.

5. The supervising nurse is on duty during week days from 8.00 a.m. to 6.00 p.m. and until 1.00 p.m. on Saturdays. The "P.O.R.R." is frequently used for night and Sunday emergencies, but so far we have not found it necessary or economically justified to employ more than one graduate nurse in this department. Student nurses serve in the "P.O.R.R." for two weeks on rotation.

6. The running expenses of "P.O.R.R." have been adequately covered by the service charge for blood transfusions. This source of revenue may disappear when the proposed free Red Cross civilian blood bank service is established. However, the "P.O.R.R." is so valuable to the hospital that it would be continued even if there was no possibility of special revenue. Medical supervision of the department has been without charge.

7. Blood grouping and cross matching is routinely done by the hospital laboratory department, but equipment for testing is available in "P.O.R.R.", and the personnel are qualified to do this work. Blood is never administered without careful cross-matching, except in the gravest emergencies, when Group "O" blood has ocasionally been given in a hurry.

8. There should be the closest liaison between "P.O.R.R." and Central Supply Room because much equipment may be common to the two departments.

Summary

A Post-Operative Recovery Room and Blood Bank organized for a general hospital of 120 beds has been described, and the experience gained in two years of successful service recorded. It is the unanimous opinion of surgeons, nurses, patients, visitors and the hospital administration that this is one of the best investments in special service which a hospital can make.

Significant Changes *in the* British Hospital System

Dr. R. McNAIR WILSON,
Formerly Medical Correspondent, The London Times

IN the British hospital system the outpatient department, so important in every hospital everywhere, occupies a place of special and increasing significance. The reason is to be found in the British "clinical tradition" which emphasizes the importance of putting practical experience in medicine and surgery before theory.

There has lately arisen in Britain the conviction that very early signs of disease exist which, so far, have not been recognized, and that if such very early signs could be recognized treatment would be placed upon a new and sounder basis. Prevention and cure might then be made to march together.

The outpatient departments of the great London hospitals, to which all the early cases of disease go, are thus much more than clearing houses for the wards. They are becoming centres of early diagnosis and early treatment, and their staffs consist of young physicians and surgeons who, as a rule, have already set up their own consulting practice. At the hospital those physicians and surgeons are unpaid; in the course of time they will be given wards in the hospital itself.

Every outpatient department has, of course, the resources of the hospital at its disposal—the special departments and the laboratories. Moreover, there exists in each a sub-division into surgical and medical clinics. Patients are classed according to the nature of their illnesses and are dealt with at all times by doctors who possess special knowledge and experience.

The equipment of the average British outpatient department is both elaborate and extensive, and is tending, as years go by, to become more complete. In a few cases beds are provided for patients who may have to submit to prolonged examination or to special methods of treatment.

Thus there is growing up the idea of a hospital within a hospital — a hospital for the diagnosing of very early disease, which is part of the hospital in which that same disease is treated when it has already become established. Under the recent stress of war this arrangement underwent further modification. The outpatient department in some places became the hospital, while the main hospital was removed into the country, out of danger of air-raids. Those cases which were not very serious and those cases in which treatment could be carried on through visits to the clinic remained in London; the more serious and more difficult cases were moved to the country.

This separation seems likely to continue now that the war is ended, and British hospitals will tend to enter upon a new phase of their evolution. There will be hospitals for early diseases and for emergencies, in which the general character of the old institutions will persist. There will also be institutions for disease in its more advanced stages, and these latter will tend, more and more, to specialize.

The Spirit of Britain

Hospital boards in Great Britain are now planning many fine new hospitals to replace those destroyed or damaged in the Blitz or outmoded by present day advances.

(Illustration from the annual report of the Merseyside Hospital Council)

The great hospital for head cases which was opened at St. Hugh's, Oxford, during the war is an example of the modern special hospital as it has developed, and is now developing in Britain. At this institution surgery of the brain is reaching a degree of perfection which even a few years ago would have been regarded as impossible of attainment, while such methods as electro-cephalography have opened up a new field of medical study.

Outpatient departments are becoming members of an outer ring of hospitals from which the inner ring of special institutions is being supplied with cases. This is already effecting important changes in medical study and medical practice. The great general surgeons and physicians who are engaged in private practice are becoming identified with the outer-ring hospitals — the teaching hospitals. The inner-ring hospitals are attracting specially trained surgeons and physicians who, since many of the special hospitals are situated in the country, may not be able to engage in private practice.

The general principle governing special and general hospitals remains strictly in the "clinical tradition". The so-called "scientific" side of medicine is subordinated to the clinical side, and science serves both doctor and patient.

—British Council Overseas Press Department.

Two Women's Hospitals Amalgamate

A new £1,000,000 hospital for women is planned as one result of the announcement of the amalgamation of two of London's oldest women's hospitals, the Hospital for Women, Soho Square, and the Samaritan Free Hospital for Women, Marylebone. The Soho hospital is believed to be the oldest women's hospital in the world. The Samaritan was founded in 1847.

The new hospital will have betweeen 400 and 500 beds and will be erected on a suitable London site. It is hoped through this amalgamation to increase greatly the rate of research into and the treatment of women's diseases, to establish "parenthood" clinics designed to inquire into the causes of unsuccessful births and to institute postgraduate teaching in gynaecology.

Hospital Architect Appointed by Department of Health and Welfare

The Hon. Brooke Claxton has announced the appointment of Mr. H. Gorden Hughes to head the hospital design division of the Department of National Health and Welfare.

The new division will be responsible for the collection and tabulation of all the latest information on the design and construction of hospitals, clinics and similar buildings. Mr. Hughes will be available for consultation with representatives of other federal departments, provincial governments, municipalities and other bodies interested in the construction of hospitals. Establishment of this division was recommended unanimously by the provincial deputy ministers of health at the Dominion Council of Health meeting last year.

Photograph by Karsh.

Mr. Hughes is a graduate in architecture of McGill University and has been practising in the Ottawa area since 1932. Among the buildings he has designed are the refinery extension to the Royal Canadian Mint and the aeronautical research buildings of the National Research Council. He is a member of the Royal Architectural Institute of Canada and a member associate of the Royal Institute of British Architects.

Since 1941 he has served with the Royal Canadian Engineers and recently returned to Canada from Holland to assist in the planning of post-war army requirements.

War Assets Getting to Hospital Items

War Assets Corporation has offered to sell to the Kitchener-Waterloo Hospital equipment in the 50-bed hospital and clinic at Kitchener, Ontario, formerly used by the army as part of No. 3 C.W.A.C. Basic Training Centre. This has now been declared surplus by the army.

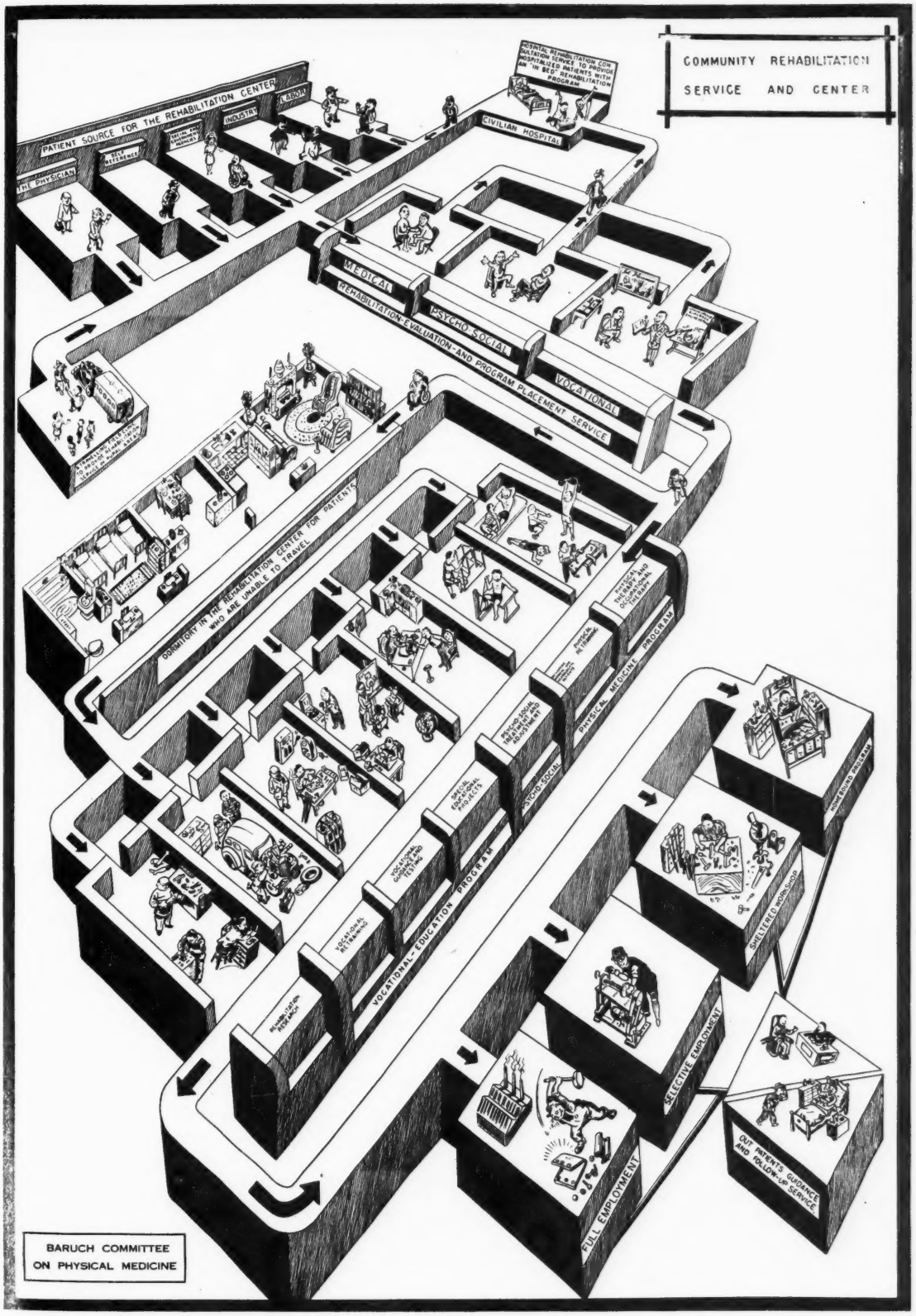
The town of Alberni, B.C., will be permitted to purchase the military hospital and nurses' home of the army camp at that point. The buildings, with about four acres of land, may be purchased for $12,771.52, which is said to be about 8 per cent of the original cost. It is understood that the hospital will be sold at once by Alberni to an industrial firm which will use it as an emergency housing for the men employed in a new pulp mill. The city will retain the nurses' home for housing.

The Health Department in one province has been notified that a certain amount of pharmacy equipment, including scales, mortars, bottles, etc., may be purchased from War Assets Corporation. However the notice was not received until within a few days of the expiration date for the receipt of tenders, which would make it virtually impossible to give hospitals sufficient notice to submit tenders.

Community Rehabilitation Service and Centre

The Baruch Committee on Physical Medicine in its initial report has recommended procedures for the guidance of committees desiring to establish curative rehabilitation workshops or centres. Hospitals are advised to establish a team of workers, made up of a specialist in physical medicine and a number of trained workers. Adequate training of all personnel is stressed.

The various aspects of rehabilitation centre activities and their interrelationships are illustrated in the "flow chart" on the opposite page.



Flow chart showing the relationship of the civilian hospital and a Community Rehabilitation Service and Centre, as recommended by the Baruch Committee. (See opposite page.)

Obiter Dicta

Saskatchewan Goes All the Way

ELSEWHERE in this issue we review the measure now going through the Saskatchewan Legislature providing hospitalization for all the people. Referring to the enactment as a "trail blazer", Premier Douglas stated that he was "pleased and proud that Saskatchewan should be the first province to launch a complete province-wide scheme of hospitalization".

The measure has several good features. It includes indigent care, an essential in any general plan. It is contributory, not state-financed, thus ensuring a greater degree of personal responsibility for its success. The government is fair to the hospitals in that any deficits in the Fund are to be made up from consolidated revenue. Arrangements may be made for the payment of hospitals outside of the province which care for Saskatchewan residents. Certain professional data are to be recognized as confidential. These are excellent provisions.

Naturally much will depend upon the regulations, for the success of any such Act is determined by the adequacy and nature of these details. The basis and amount of payment for services rendered must still be announced. This of course is fundamental to the existence of the hospitals. The definition of "Commission" is very broad and may indicate the setting up of a new Commission; in that case no indication is given as to its composition, or how members will be appointed. We hope that the hospitals will have direct representation. By the inclusion of x-ray and laboratory procedures and "anaesthetics", a measure of medical participation is implied. To what extent will outpatient patronage or admission for diagnostic procedures only be recognized? We miss the safeguards in the Federal "model act" of two years ago which put non-profit voluntary hospitals and municipal hospitals upon "an equal footing"; which gave the patient the right of selecting a hospital; and which gave the hospital the right to control its staffing policy in the interests of sound medical care. We hope, and presume, that these will be included in the regulations.

The *Hospitals Standards Act* permits regulations of a very sweeping nature controlling the construction and administration of hospitals. Exercised with reason, these regulations should result in highly efficient and economical service; they could, however, be made highly discriminating in the hands of an unsympathetic or dictatorial government. The taking over of so much "control" by the Government must not be overlooked by the voluntary and municipal hospitals.

C.M.P.A.B. Completes Task

THE Canadian Medical Procurement and Assignment Board has now completed its work and will shortly be disbanded. Although little publicity was given to the work of this Board, its achievements were far-reaching and were of tremendous value in furthering the efficiency not only of the Medical Services but also of the civilian population during the war years. This Board was set up in 1942 by the Department of National Defence to achieve efficient and equitable mobilization and distribution of medical and dental personnel for both civilian and Defence needs. It was made up of representatives of the medical and dental services of the three Armed Services, Pensions and National Health (now divided), the Canadian Medical Association, the Canadian Dental Association, the Department of Labour, the Association of Canadian Medical Colleges, the Royal College of Physicians and Surgeons of Canada and the Canadian Hospital Council. The latter was represented during the most active period by Dr. Stephens and more recently by its Secretary. To assist the Central Board, Divisional Advisory Committees (D.A.C.'s) were set up in each province. Later the field was widened to include nurses and medical and dental technical personnel.

Altogether over 5,000 medical officers were appointed to the three services and the C.M.P.A.B. and the D.A.C.'s had much to do with the procurement of these doctors. The National Health Survey, an exhaustive study of health facilities and needs in Canada, was initiated and completed by this Board. This study, in which our hospital associations took an active part, was the most extensive ever made in this country. The Board also published a valuable guide for returning medical officers entitled "Facts About Your Medical Career on Demobilization". This outlined refresher and postgraduate facilities available.

A very important activity was the secondment of volunteer medical officers to communities or institutions badly in need of medical assistance. Under this plan doctors were seconded at the usual pay and allowances of an officer, usually that of a major, provided the province guaranteed reimbursement to the Armed Service concerned. Some 42 officers were so placed and more would have been placed if all of the provinces had agreed to guarantee the costs. The plan proved a godsend to many communities, moreover it also had an interesting effect in that the outcry raised in some areas about the shortage of doctors died down rapidly when it was shown that

doctors were available provided the community or the province agreed to pay his salary. The Board also supervised the assignment of over 2,000 senior medical students enlisted under the accelerated training programme. The Board has made a complete registry on a punch-card basis of all medical and dental men in Canada. It has secured priority releases of many doctors for special civilian needs; it has advised the Government on Labour Exit Permits for physicians and dentists; and it has helped to improve the intern situation in many hospitals.

This organization has been so valuable that is is hoped that machinery can be set up to permit its immediate reorganization should another war or national emergency arise. Although this present Board is being disbanded, some of its functions might well be continued. For instance, the National Health Survey should be kept alive and up-to-date by repeated re-checks and revisions. The highly valuable data on physicians and dentists, now being coded on the Hollorith machines, should be kept available and be periodically revised. Some avenue of official contact between the federal departments and the doctors, nurses and hospitals, such as was created by this Board, should be perpetuated; hitherto our contacts have been haphazard and only as the departments or associations saw fit to consult each other. The present Dominion Council of Health does not meet the situation. This need was recognized by the members present at the last CMPAB conference and the possibilities of setting up some such co-ordinating body are being explored.

A Public Health Problem

THE provision of adequate facilities for the care of communicable diseases is becoming an increasing problem in most cities, a situation complicated by the fact that the average occupancy of the isolation hospitals is steadily dwindling. As facilities and personnel must be maintained to meet unforseen emergencies, the average per diem cost is steadily rising.

A special problem exists in connection with the Alexandra Hospital for Infectious Diseases serving the Montreal metropolitan area. This hospital of 168 beds has been serving its community for some forty years. Unlike most isolation hospitals its deficits are not the responsibility of the municipality, as in the case of the Pasteur Institute, the isolation hospital for French-speaking patients in Montreal, as the former was founded by private subscription when such facilities were badly needed. It receives so much per patient-day from the city and still depends in large part upon its endowment, now yielding a much reduced income, and upon gifts. It is now running a deficit of some $25,000 a year, the gross deficits being close to $40,000 annually. With the reduction in patients and the shortened period of hospitalization resulting from modern preventive and therapeutic methods, not to mention the general increase in operational cost, the per diem cost has risen from $3.60 in 1940 to over $5.00 per diem at present. Despite these increases, the city's per diem payment has not been increased but was actually reduced some two years ago.

Some thought has been given to the proposal to convert part of the now less-used accommodation to the care of tuberculosis patients, particularly in view of the large number of children with open tuberculosis for whom accommodation is now lacking. This would help, although it is questionable if the hospital could meet operational expenses even then. The care of patients with communicable disease is primarily a municipal responsibility. The city may argue that it has its own isolation hospital now and patients should go there. This involves a point which is not a simple matter in a bilingual city. Supporters of the Alexandra Hospital, recalling its long years of service, feel that it has a just claim either to increased municipal grants or to guarantee to have deficits met or both.

Friendly Societies Unite To Oppose Government

AT a national conference of the Friendly Societies in Great Britain is was agreed to fight the Government in its intention not to use the Friendly Societies in the Government's insurance scheme. This controversy will be of considerable interest to us here, for we are now entering the period when policies with respect to social insurance must be made.

The Friendly Societies, corresponding to our "lodges", were at a low ebb back in 1910-11 when Lloyd George was proposing his health insurance measure. As here, lodges had passed their hey-day and were not attracting the young people. To gain support for his measure Lloyd George proposed that the plan be developed *through* the Friendly Societies. Some years ago he admitted to a prominent Canadian representative studying European insurance plans that this was done only because of political expediency and that if he were doing it over again this arrangement would not likely be made. However, to the Friendly Societies this meant a new lease of life. Naturally their membership grew and so did their reserves, amounting now, we are informed, to many millions of pounds. Of still more significance they are now a strongly entrenched organization coming between the Government and the people. They wield tremendous political power, influencing the opinions of many millions of their members and thus putting pressure on the government. This power, which some think has become unbreakable, is much regretted by many people and it indicates the courage of the present government in announcing its intention of cutting adrift from this influence. Obviously the Ministry realizes the importance of freeing government action before it is too late. The Friendly Societies, seriously alarmed, are talking of a nationwide campaign, the formation of a Friendly Societies group among the labour members of Parliament and even of fighting by-elections.

For years British contacts, ranging up to government officers, have warned us to beware of similar entanglements. The Canadian Hospital Council has already expressed itself as favouring an administration by a non-political Commission broadly representative both of those receiving the services and those rendering it. A direct relationship between these groups and the controlling body is highly desirable.

appointed to secure knitters, and members who could not knit supplied money to purchase wool for those who could. Many articles, too, have been donated by friends and well-wishers. This branch of the work is of particular interest on the obstetrical ward and is a source of revenue for the Aid.

Of necessity readjustments will take place as the work progresses. Joint convenors allocate times for volunteers to visit the wards from 2 to 4 o'clock in the afternoon with the shop, banking, checking supplies and keeping a full stock on hand. This requires considerable time and thought, and the Aid is fortunate in having women prepared to give this service.

Travelling Tuck Shop

MRS. T. J. LYTLE,
Women's College Hospital Aid
Toronto

The Hospital Aid, an affiliated branch of the Women's College Hospital at Toronto, has been working for ten years, with its main objective the raising of funds for the hospital. Two years ago, wishing to expand their work to include active service within the hospital, the President approached the superintendent of the hospital, seeking avenues of service. War years had created problems for hospitals, such as shortage of nurses and labour and non-deliveries to patients. Two pressing needs were suggested: the making of dressings in the supply room, and a tuck shop which would take care of the patients' needs. Supply room work was undertaken immediately, but ways and means for a tuck shop required more consideration. One of the members stated that her husband would supply the shop if provided with the necessary information as to size. Measurements of doorways, elevators, etc., were taken, and a very fine shop on wheels was delivered to the hospital and put into use at once.

Supplies were purchased to meet the needs of shut-ins, such as magazines, note paper, thank-you cards, stamps, cosmetics, toothbrushes, toothpaste, etc., and priority goods when available, such as Kleenex, chocolate bars and gum.

One shelf was reserved for knitted baby articles. A convenor was

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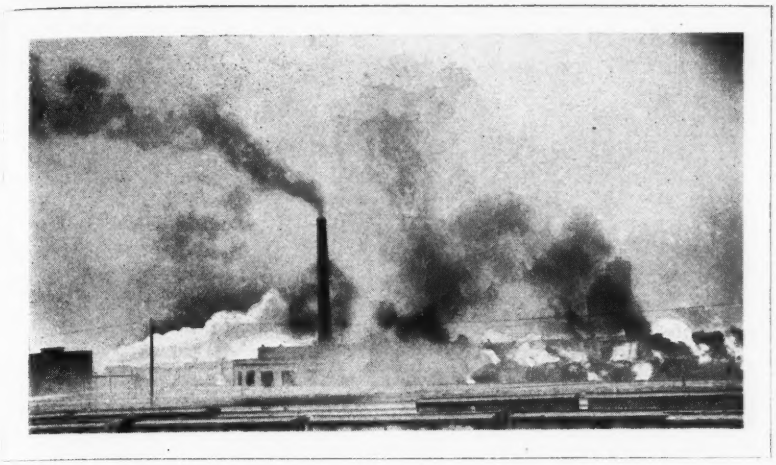
Brigadier G. R. D. Farmer Appointed to D.V.A.

The appointment of Brig. G. R. D. Farmer of Hamilton as deputy director-general of treatment services has been announced by Hon. Ian Mackenzie, Minister of Veterans Affairs. Brig. Farmer will supervise the department's medical administration throughout Canada.

Born in Ancaster, near Hamilton, Brig. Farmer attended Upper Canada College, was graduated in medicine from the University of Toronto and took postgraduate work at the University of Paris. He went overseas in 1939 in command of No. 5 Canadian Field Ambulance and in June 1944 was awarded the C. B. E. for outstanding service in the battle of Caen. Having seen service in France, Holland, Belgium and Germany he returned to Canada after VE-Day to become deputy director-general and has been acting as director-general in recent months.



Smoke and Health

Condensed from an article by Clarence Mills, M.D., Professor of Experimental Medicine at the University of Cincinnati, in the Rhode Island Medical Journal.

THE Industrial Revolution and modern machinery have wrought great changes in human existence, and some of these have been mixed blessings. The growth of large metropolitan centres of great population density and the use of enormous tonnages of coal for heat and power have created certain hazards to health, the true seriousness of which are at last being realized. Close analysis of the health damage wrought by such air pollution provides an ample basis for smoke clearance campaigns, entirely aside from any probable reduction in laundry bills, painting and decorating costs, etc.

The average person takes two to three quarts of food and drink in through his mouth every day, but in the same time he takes into his lungs *10 to 12 thousand quarts* of whatever atmosphere happens to be around him. Most of the dirt or pollution in this large volume of inspired air is caught and held in his respiratory system.

Early in the present century Ascher pointed out the increased respiratory disease hazards faced by people living in atmospheres polluted by coal smoke. He found the pneumonia mortality 135 per cent higher in men of the Ruhr valley than in Prussian men of similar age groups, with the death rate highest in the industrialized areas of worst pollution. Pneumonia caused six times more nursing deaths in industrial than in rural populations. He also found that coal smoke quickened tuberculosis deaths in laboratory animals and increased their susceptibility to aspergillus pneumonia. The damaging effect on people was greatest in those industrial areas where humidity was high and fogs prevalent.

In 1912 White and Marcy presented data showing a close relationship between sootfall and pneumonia death rates in the 27 wards of Pittsburgh; with tuberculosis the relationship was less regular but still significant. They used only total mortality data, making no breakdown by sex or colour. In 1938 Haythorn and Meller found that it concerned Pittsburgh men much more than women, for the male death rate from penumonia was 50 to 90 per cent higher than the female in each year studied.

Certain industrial cities present sharp local differences in the degree of pollution, due to their local topographical features. In order to supply definite information on the health aspects of smoke pollution, a close survey was made of sootfall and respiratory disease rates in the 19 sootfall districts of Cincinnati and the 96 of Pittsburgh. Graphs show the sootfall in both cities to be highest in the low-lying areas of the river bottoms, and indicate the close relationship of high pneumonia death rates (male, white only) to heaviest sootfall.

In Cincinnati the 10-year average sootfall ranges from 134 up to 1,544 tons per sq. mil. per year, while in *20 months* of 1938-40 that of Pittsburgh districts varied from 28 to 400 tons per sq. mi. per month. Male, white penumonia rates varied from 41 to 165 per 100,000 population for Cincinnati and from 0 to 7,852 for Pittsburgh. Not only are both sootfall and pneumonia rates much higher in Pittsburgh than in Cincinnati, but in both cities they are highest in the low-lying industrial area.

A similar close relationship exists between pneumonia rates and such socio-economic indices as rental values, degree of overcrowding, family income, etc., as between these indices and sootfall rates. It has been assumed in the past, therefore, that the high respiratory disease rates of slum areas are more likely due to these adverse socio-economic factors. A definite indication that such is not the case is obtained by comparison of male and female rates. In the cleaner air of the high suburban districts little difference exists between male and female pneumonia or tuberculosis rates, but in the polluted air of the bottoms districts the increase in male rates is almost twice that of the female . . . It would seem obvious, therefore, that something other than socio-economic factors must be at work, for such factors would affect the women fully as much as the men with whom they live. Indeed the men are usually better nourished than the women and spend less time each day in the crowded family living quarters. In the 96 sootfall areas of Pittsburgh the ratio of male to female penumonia death rates bears a significant relation to sootfall with a correlation cofficient of + 0.2947 +/— 0.0642 and a chi-square value of 15.2, meaning that male pneumonia

deaths predominate more the greater the atmospheric pollution.

It might be suggested that men of low economic groups would be exposed to more frequent chilling than would their wives, that their high pneumonia rate is due to their greater outdoor exposure. Such a suggestion is negatived, however, by the fact that rural males of Ohio have very little more penumonia than rural females (4 to 5 per cent) and by the fact that there is very little sex difference in suburban areas of industrial cities. In both Cincinnati and Pittsburgh, pneumonia rates also fall rapidly with each 100 feet of ascent above the bottoms districts. This does not mean that altitude *per se* affords protection against pneumonia, but that people living on the city hilltops escape most of the polluting material which is discharged mainly into the air of the bottoms districts. Railroads enter into these cities along valley routes, and industrial users of coal have located largely along the railroads.

Cancerigenic Materials

The first suggestion that coal smoke contained cancerigenic materials originated half a century ago with the observation of a high frequency of skin cancer among London's chimney sweeps. Since then a variety of very potent cancer-producing compounds have been isolated from the coal tar which condenses upon the soot particles of smoke when coal is burned with a smoky flame. These compounds volatilize at the low fire-box temperatures which favour smoke production, while at the higher temperatures of stoker-fired furnaces they are almost completely consumed.

Because tissues of the air passages and lungs come into contact with so much more of the contaminated air of industrial cities than does the skin of any other body structure, one might well expect them to show a higher prevalence of cancer development. Doubtful success has attended experimental efforts along this line with susceptible mice, perhaps because the extremely fine smoke particles which penetrate into the air sacs of the lungs have not yet beeen used. Although the evidence (comparison of mortality rates with regional differences in smoke pollution) strongly suggests the presence of cancerigenic air contaminants in the smoky districts, the proof of its relation to human cancer is still not entirely settled.

The smoke problem is worst on days of low air movement and in the cooler seasons when there are more water particles in the air to hold the soot and fly-ash suspended. Boiler steam discharged from fixed and movable power plants plays an important part in cold weather fog formation, for cold air has little water-holding capacity. No attention has been given to this phase of the smoke problem, although it is an important part of the matter. Industrial power plants condense most of their waste exhaust steam for heating purposes during the cooler seasons, but railroad engines belch forth into the atmosphere their entire output of boiler steam, and in it are mixed their coal combustion products. Forced draft in the fire-box blows large quantities of fly-ash as well as cinders out with the steam. It begins to appear, therefore, that the movable steam engine may be providing one of man's worst winter health hazards in urban areas.

Pure carbon soot is probably harmless but flue carbon arising from soft coal combustion has condensed upon it a varying load of coal tar; a fact of great possible importance because of the cancerigenic compounds contained in the tar products. Fly-ash is probably the most harmful smoke constituent. Chemically it is a siliceous mixture somewhat similar to the rock dust which has killed hundreds of quarry and tunnel workers from silicosis. While outspoken silicosis is uncommon among city residents, it is possible that a lower grade of irritation in sinuses, air passages and lungs may be responsible for much of the increased respiratory disease hazard in polluted urban atmospheres. Sulphur gases in coal smoke add to this fly-ash irritation, particularly when coals of high sulphur content are burned.

Discussion

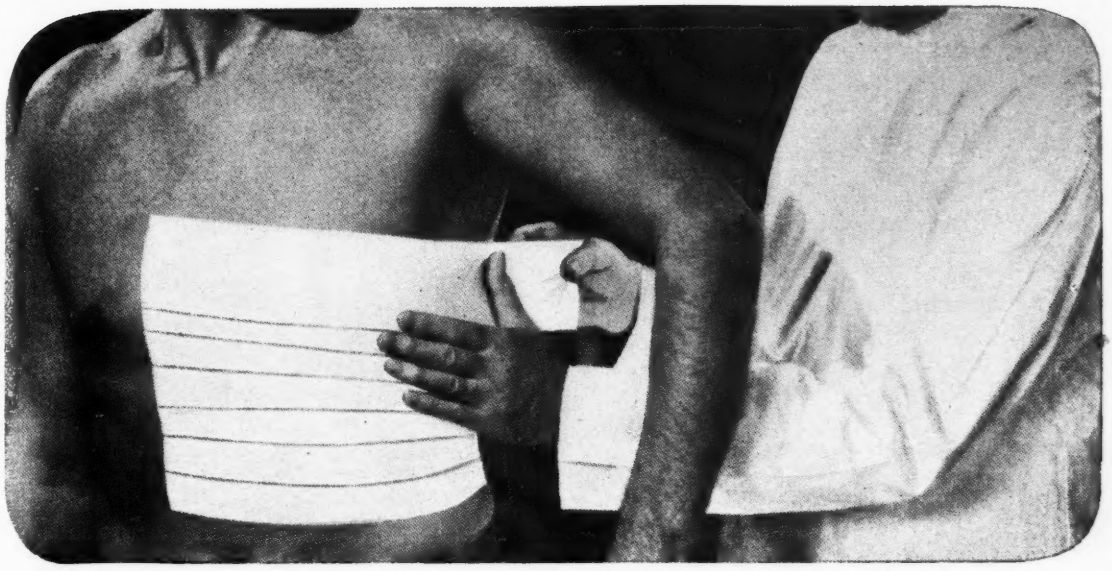
There now seems little doubt that coal smoke pollution of city atmosphere constitutes a health problem of the first magnitude. Pneumonia, tuberculosis and lung cancer are all markedly more prevalent among people living in the most polluted areas of industrial cities. Doubtless a similar situation would be found for sinusitis, bronchitis and other minor respiratory diseases if reliable statistics were available. The fact that this respiratory hazard is so much greater for men of the city labouring classes than for their wives and that rural outdoor labourers face no such increased respiratory danger, points to atmospheric pollution as the responsible factor.

A half-century ago city water supplies were purified only after it had been clearly demonstrated that their pollution was responsible for widespread sickness and death from the enteric fevers. So we may now see earnest attempts at clarification of city atmospheres, in view of the evidence set forth in these pages. It will cost something for this elimination of air pollution, just as it did for water purification. It should be borne in mind, however, that disease itself is expensive. Respiratory diseases (including influenzal infections) account for about 70 per cent of the working time lost by employed persons on account of illness. A saving of even two such lost days a year for each employed person would probably pay the total cost of smoke clearance in any city.

Remedial steps to be taken should cover four points. Output of carbon soot and the coal tar products should be prevented by use of low-volatile coals or of proper mechanical equipment to burn the high-volatile varieties smokelessly. Escape of fly-ash should be controlled by proper trapping devices and reduction in stack or flue draft. High sulphur coals should receive preliminary washing. Railroads should be compelled to change to Diesel or electric power within metropolitan areas. The time has arrived when the smoke problem should be considered on a health basis alone, without regard to the dry-cleaning or laundry savings which would accrue from smoke elimination.

Hospitals by Sea

The first of thirteen United States army hospitals purchased by U. N. R. R. A. and destined for Poland and Yugoslavia left Newcastle, England, in January by sea. Eleven of the hospitals are 1,000 bed general hospitals, one a 750 bed evacuation hospital and the other a 400 bed field hospital. In addition to the 1,000 beds, each general hospital includes a laboratory, operating rooms, x-ray department, kitchen, laundry, and offices. A complete hospital comprises nearly 3,000 packages.



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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

As some of your readers may have shared your kind interest in the foundation of the College of Speech Therapists (recorded July, 1945) it seems desirable to add a note of an important development springing from it.

The Minister of Education has issued a memorandum to local authorities, in which he explains that there have been certain changes in the courses of training for speech therapists and in the actual work in which they are employed. In England the training is now given in four training schools, each of which is maintained by, or conducted in close connection with, a hospital and comprises instruction in anatomy, physiology, neurology, pathology of the ear, nose and throat, phonetics and speech therapy. It does not include training in teaching, in handling classes of children or in school practice. Correspondingly the work which the speech therapists have to do has been decreasingly educational and more curative. It is carried out in part at least under medical supervision and the only persons whose employment as speech therapists is approved by the Minister are those who have been admitted to the Register of Medical Auxiliaries.

The Minister's memorandum is a valuable recognition of the status of speech therapists, especially as he goes on to say that they shall be treated as members of the staff of the School Health Service and shall not thereafter be regarded as teachers. At the same time the Minister has fixed a scale of salaries, which goes a good way to remove dissatisfaction on that point, by placing them on a level more nearly approaching to that of analogous occupations, such as occupational therapists and radiographers.

Speech therapy is sometimes required for the assistance of discharged service men and as there has been some difficulty in obtaining the services of therapists owing to the limited supply of duly qualified people, the Minister has approved an arrangement by which the authorities of the hospitals of the Ministry of Pensions may apply to the local authorities to make an arrangement with their staffs, which may also apply to men after their discharge from hospital.

Some Interesting British Developments

A Centre for Medicine

Canada Walk, of which you may have heard in the national press, commemorates the location of the headquarters of the Royal Canadian Air Force in London during the years when they occupied the Land Registry Office. On the same side of Lincoln's Inn Fields, within the ambit of Canada Walk, is the Royal College of Surgeons. Between the two buildings is a large gap effected by enemy action. The College, under the Presidency of Sir Alfred Webb-Johnson, have taken the lead in a proposal to establish a medical centre by bringing together the three Royal Colleges—Physicians, Surgeons, Obstetricians and Gynaecologists. At the moment the Royal College of Physicians, through their President Lord Moran, have replied that their present interests would best be served by remaining in their present premises. It is an interesting coincidence that the College of Physicians is also linked with Canada, as their building constitutes an island site with the headquarters of the High Commissioner of Canada in Trafalgar Square. There is need for the extension of the existing accommodation so if Canada purchased the site of the Royal College of Physicians a contribution might thereby be made to the establishment of the medical centre. In the meantime the Surgeons have decided to keep the present opportunity open by retaining the properties which they have acquired in the hope that on future consideration the Physicians will decide to co-operate in the establishment of a medical academic centre in Lincoln's Inn Fields. They believe, according to a letter addressed by them to the Physicians, that such a centre "in which each college would retain its identity, would have great imperial and international influence. It would be a centre of research and learning. It would be able to retain liaison with the Dominions and foreign countries, to arrange and conduct international congresses and provide for the organization of research and the publication of standard medical literature in foreign languages".

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Here and There

By the Editor

The Mystery Man at Cornwall

The situation at Cornwall last month, when a stranger in town claimed to be a medical man and to have hailed from either Germany or Austria as the idea appealed to him, could have been a serious one had he not been detected. The story developed many versions in the press; apparently he was not employed at the Cornwall General Hospital as an intern, nor as an orderly, but for one brief period in a non-medical capacity. However his claim to be a graduate of the London Academy of Medical Arts and Sciences did impress people. It was when he claimed to have been a medical student at Dalhousie and a medical graduate of British Columbia, which does not have a medical school, that he got into difficulties that led to his identification as a fugitive from justice from Lethbridge.

Few people ask to see a doctor's credentials and few could evaluate them if they did see them. In contrast to the system on this continent, where medical schools are either Class "A" on the A.M.A. list or are unrecognized, European schools are without any grading by a recognized authority. Some are among the finest in the world; others would be hopelessly ineligible under the A. M. A. standards (the ones by which all Canadian schools are approved). It is this lack of a yardstick which makes it difficult for licensing bodies to determine the qualifications of applicants from many continental schools. Although an imposter, conceivably, could serve quite an internship without detection since a license to practise would not be required, it would be difficult for him to carry on a practise because of the care taken by the registrars of the licensing colleges. Nevertheless it has happened.

Nurse Shortage

We may feel that the shortage of qualified nurses in Canada is serious but we are not as badly off as they are in India. It is estimated that some 800,000 more nurses are needed for that country. There are now some 7,000 nurses only. This works out at about one nurse per 55,000 of population.

* * *

Herman—the Gullible Gull

Doctor Wallace Wilson of Vancouver, President-elect of the Canadian Medical Association, though a bird lover of note may have seriously jeopardized his standing with the Audubon Society. The other day, standing by the partly open window of his ninth floor office which overlooks the majestic beauty of Vancouver harbour, he was watching Herman, one of his feathered friends, put on his daily exhibition of graceful gliding and banking. Spying the doctor and knowing that humans may mean food, Herman coasted in to the window-ledge on the off chance of a meal. He got one.

First the naughty man tossed his lighted cigarette onto the ledge. Down it went in one gulp but, fortunately for Herman, the lighted tip fell out as it struck the sill. That was good; he wanted more. Seeing some brightly coloured diuretic tablets nearby, the doctor tossed them out; like a flash they disappeared. More? Sure! How about some vitamin samples of the shotgun variety and good for everything? Down the hatch they went, too. How about some special pills for those dizzy spells from high flying? They joined the others. By this time beady-eyed Herman was half inside the window. Hunting for some more samples, the doctor saw the very thing—a box of haemorrhoid suppositories. Herman was overjoyed. That tasty cocoa butter was a delightful change from dead fish and grapefruit rinds. One by one the whole boxful disappeared. It may have been his imagination but by this time the doctor thought that Herman was not quite so beady-eyed; in fact he was sure of it. With sound clinical judgment, our friend brought the banquet to a speedy termination with a final treat—a half dozen A.B.S. & C's. After this debauch, Herman flew solemnly away.

* * *

Dr. Anderson Honoured

Dr. A. F. Anderson, the genial but hard-hitting administrator of the Royal Alexandra Hospital in Edmonton, was elected a life member of the Dominion Curling Association at its annual meeting held recently in Saskatoon. Dr. Anderson has long ben active as a curler and in 1940 was president of the Dominion Association. In 1942 the Royal Caledonia Club, at its annual meeting in Edinburgh honoured Dr. Anderson by electing him its vice-president. With his broken hip gradually returning to normal again, he should be in good shape by next winter to show the young fellows how the old masters do it.

* * *

Stainless Steel Up

Last month the Allegheny Ludlum Steel Corporation, one of the major independent producers of stainless steel, announced that it was increasing immediately the price of stainless steel by 8.2 per cent. This increase is equivalent to that granted to steel producers as recently announced by O.P.A. This price advance was made to offset the large increases in material and labour costs affecting stainless steel, culminating in the 18½ cents increase in wages just granted.

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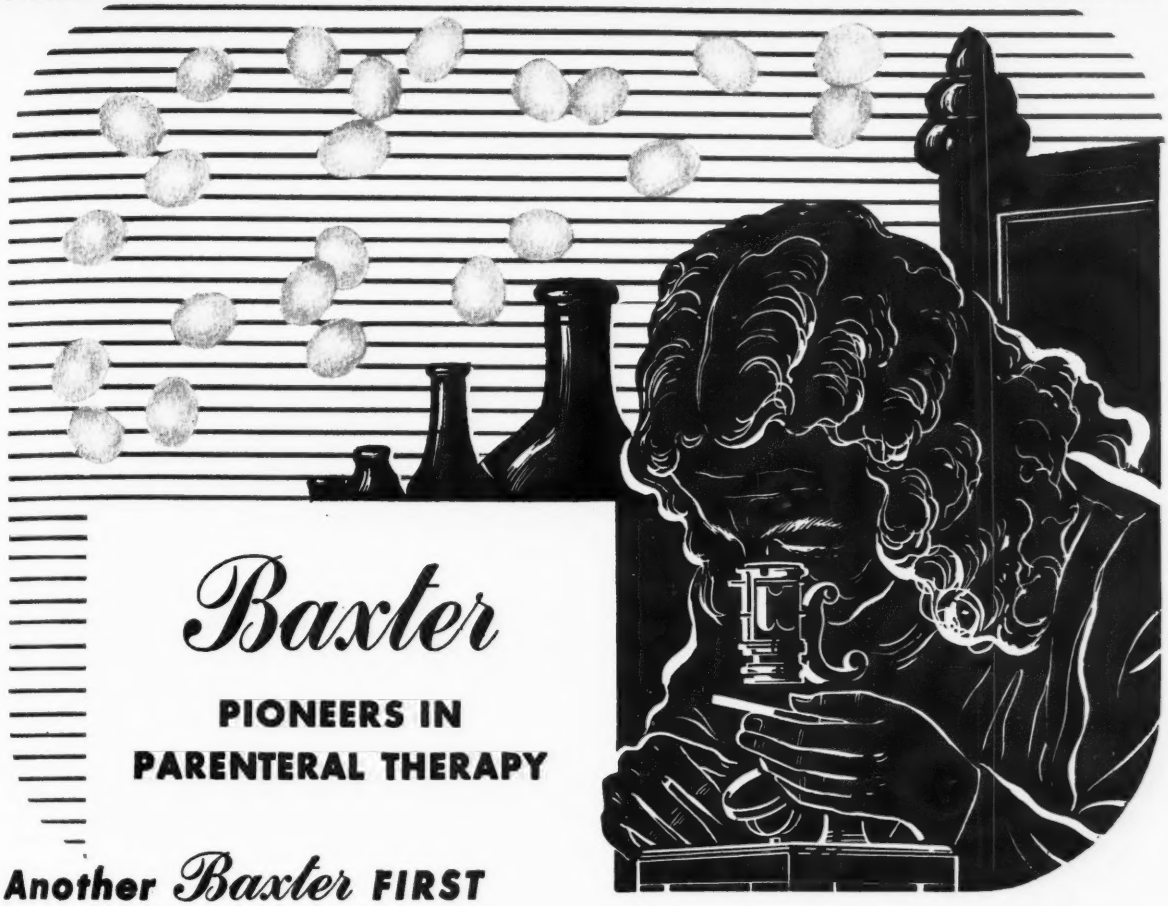

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PIONEERS IN PARENTERAL THERAPY

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With the Auxiliaries

Maritimes

In *Sydney* the Junior Aid counted a "penny auction", a dues social and a spring tea and sale among its money-raising activities for the hospital.

The Senior Auxiliary recently installed an electric sewing machine, and have also purchased an incubator and a cystoscope.

The J. H. Dunn Hospital Aid of *Bathurst,* N.B., has raised substantial sums of money during the year, as well as donations of vegetables, jams, jellies, etc. A strong membership drive is being undertaken, and among the aid's objectives is the redecorating of the hospital rooms.

The Saint Charles Auxiliary at *Charlottetown* announced at its annual meeting a gross income during the past year of $2,033.69. Mrs. J. J. Duffy was elected the new President.

Ontario

Windsor, Ont., Hotel Dieu Aid, celebrated its silver anniversary with a banquet. Since its formation in 1921 it has given almost $20,000 to the hospital.

Sudbury has reported a paid-up membership of seven hundred and twenty-five. The executive is working in co-operation with a Citizens' Committee in planning for a new community general hospital. Groups are making roses for the Rose Tag Day May 12th—National Hospital Day—and Mother's Day. Three thousand cook books are going on sale shortly in aid of the Hospital Aid Fund.

In *Toronto,* Mount Sinai Aid has raised eight thousand dollars during the past year. Various groups comprise the Women's Hospital Aid Council, each group doing a specific work and foregathering as a council in general meeting.

The Women's College Hospital Aid raised three thousand dollars with their annual "January Nite".

Guelph Junior Aid is a particularly active group, and issues a monthly bulletin to keep its members in touch with the work done or needed.

Belleville Aid held a successful Community Bridge and plans are now under way for a Spring Fashion Show. It has recently purchased a humidicrib and is planning the purchase of an orthopaedic table, delivery table and table for the E. E. N. T. Department.

Niagara-on-the-Lake Aid is planning a list of activities which will help in raising funds for more adequate hospital accommodation.

Chatham General Hospital Aid is doing some particularly fine work. The Ladies' Assisting Society provided $2,000 for the furnishing of an 18-bed unit and the Heather Club furnished the living room at a cost of $500. The Junior League Aid and the North Harwich Aid (rural group) also contributed $500 each for furnishings for the Priscilla Campbell Nurses' Home. This Aid comprises five groups, and it is expected that two more will be added this spring.

* * *

Manitoba

At the annual meeting of the *Morden* Hospital Aid a satisfying record of activity throughout the year was given. The members of this Aid have as their principal objective the supplying of the hospital with linen and dishes, and in addition to this the decoration of the nurses' home, on which $403.00 was spent last year. Mrs. W. R. Leslie was elected the new President, with Mrs. J. M. George as First Vice-president.

* * *

British Columbia

The Auxiliary of the *Vancouver* General Hospital, which numbers about eighty members, has had an exceedingly busy year. For instance, the social service committee of the Auxiliary records: "Supplied through the auxiliary were 86 pairs of glasses, 60 sets of dentures and dental repairs, 43 surgical or medical appliances, including one artificial limb, 3,850 street-car tickets, $128.50 worth of milk tickets and 71 taxi fares and 19 ambulance fees paid.

Congratulations!

Mr. and Mrs. W. R. Chenoweth of Montreal had the happy experience recently of being present when two of their sons received awards at the Government House investiture. A. — Lieut.-Commander Richard C. Chenoweth (on left), who received the O.B.E., was Commander of the frigate H.M.C.S. "Runnymede". Lieut. Ian B. Chenoweth, who received the D.S.C., was First Officer on the frigate H.M.C.S . "New Glasgow".

A third son, Lieut. David Chenoweth, was an officer on the frigate H.M.C.S. "Huron" and was in the engagement at the sinking of the German battleship "Scharnhorst". Subsequently he was transferred to the Naval Base H.M.C.S. "Cornwallis" where he was appointed an anti-submarine instructor.

Mr. Chenoweth is a Past-president of the Canadian Hospital Council. He is now Secretary-Treasurer of the Lyman Tube and Supply Company, Limited, of Montreal.

Revised

Rules and Regulations

of the

Canadian Society of Laboratory Technologists

(Effective July 1)

THE Canadian Society of Laboratory Technologists has announced the following rules and regulations for examination for membership in the Society, to be effective as of July 1st of this year. Prospective students are urged to note these rules.

1. *Age:* Minimum age of 18 years.

2. *Education:*

Senior matriculation or the equivalent standing in the various provinces. Two science subjects are required, one of which must be chemistry. The required standing in the various provinces is as follows:

British Columbia — Senior Matriculation.

Alberta—Grade XII.

Saskatchewan—Grade XII.

Manitoba—Grade XII.

Ontario—Senior Matriculation or Grade XIII.

Quebec—Senior High School Leaving Certificate or Senior Matriculation of McGill.

New Brunswick—Senior Matriculation or Grade XII.

Nova Scotia—Grade XII.

Prince Edward Island—First Class Licence Certificate of the Department of Education or Third Year Certificate of Prince of Wales College.

Newfoundland—Senior Associate Diploma.

A transcript of educational credits must be submitted with registration forms. Certificates will be returned upon request.

3. *Student Registration:*

Students desiring to take a course of training are requested to make application for registration before starting the course. The fee is $1.00 and this entitles the student to receive the *Canadian Journal of Medical Technology,* the official publication of the C.S.L.T. This registration will help to avoid delays in approving the application for examination at the end of the course.

4. *Application for Examination and Fee:*

i. $15.00 payable with application for examination and registration forms. ($3.00 of this is for the first year membership fee.)

ii. Depositing of above payment does not necessarily mean approval of application for membership.

iii. Fee will be refunded if application is not approved.

iv. In case of failure in the examination, applicant may try again within a year for additional fee of $5.00.

v. No applicant will be accepted for examination a fourth time.

vi. Membership fee of $3.00 (included in $15.00 above) will be refunded upon request if student fails and does not wish to re-write examinations.

vii. Application form, registration form, fee and a photograph, must be returned not later than April 1st for spring examination and October 1st for fall examination.

viii. In case of failure application must be made not later than above dates for the next examination.

ix. Note: Applications received after the above dates cannot be considered until the next examination.

5. *General Certificate:*

Applicant must have had at least 12 months' training in an ***approved school*** covering the various subjects of medical laboratory technology.

6. *Specialist Certificate:*

(a) Applicant must hold a general certificate and have had at least two years' experience in the specialty. Examination fee is $5.00 per paper and only one specialist examination may be taken in any one year. *Or*

(b) Applicant must be a university graduate in biological sciences and have had two years' experience in specialty. Fee is $15.00 for initial paper and only one specialist examination may be taken in any one year.

7. *Examinations:*

Examinations are held twice yearly, in the latter part of April and the latter part of October. The examination is in three parts, oral, practical and written. *Pass Mark:* 50% on each subsection and a mark of 60% on the total. All applicants must take the examination.

8. *Annual Renewal of Membership:*

Renewal of membership for each individual year must be made by returning the renewal form, together with the annual fee of $3.00, by January 1st of each year. Membership card will not be issued until ***both*** have been received. Any member being four months in arrears may be suspended by the Executive but may be re-instated upon payment of arrears.

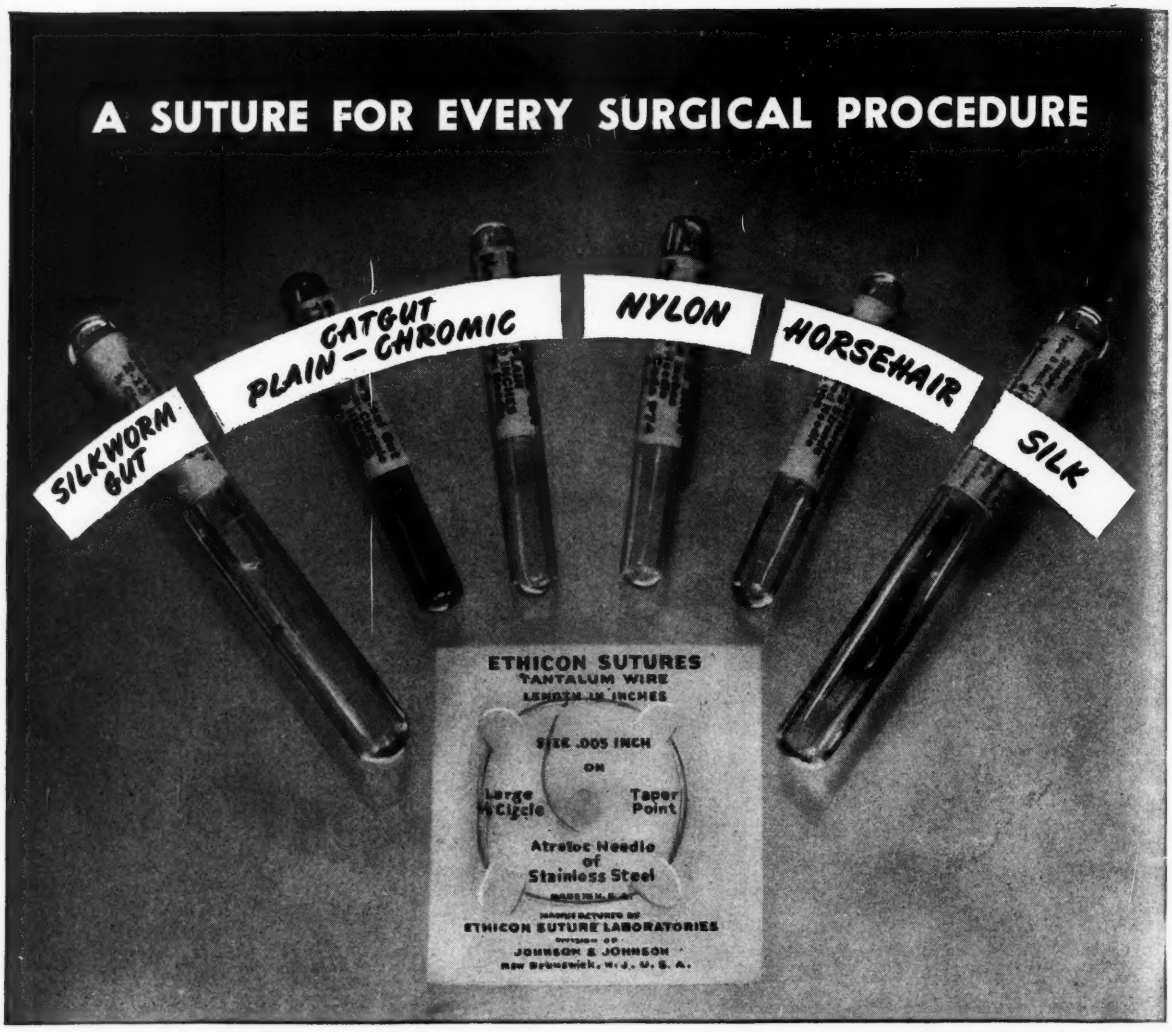
9. *Applicants in the Armed Services:*

Until further notice, applicants who are doing or have been doing medical laboratory work in the Armed Services will be given individual consideration by the Executive in regard to their educational standing and laboratory training.

Wing-Commander Franks to Head Institute on Aviation Medicine

The Hon. Colin Gibson, minister for air, has announced that the parent institute of the Institute of Aviation Medicine is to be located at the Eglinton Hunt R.C.A.F. station in Toronto, and is to be in charge of Wing-Commander W. R. Franks.

Toronto was chosen for headquarters of the research because of the university and other research institutions, and because of its favourable geographical location.



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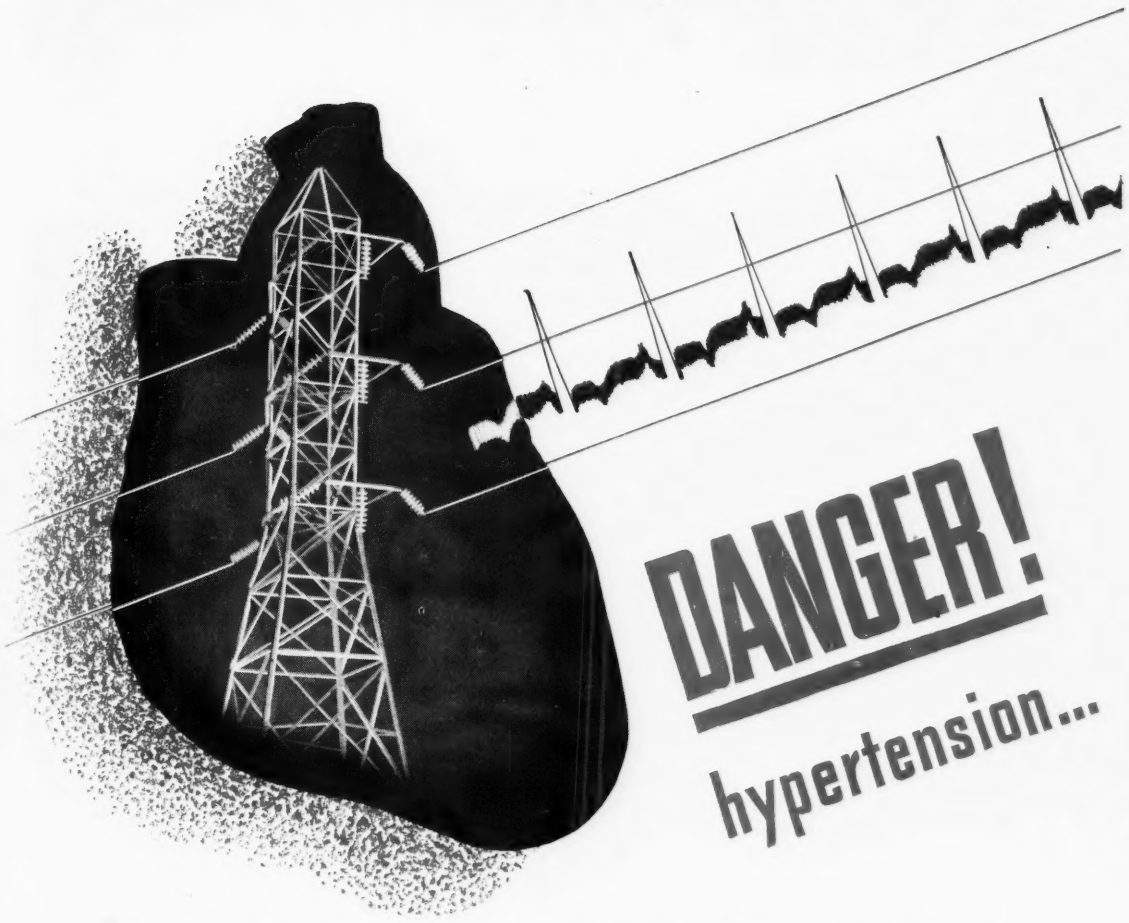

DANGER! hypertension...

Like a high-tension line, the condition of hypertension represents a graver *potential* than actual danger. Anxiety, worry and nervous excitability are the real threats which must be avoided at all costs.

Once the tests have been made, the results checked and the diagnosis confirmed, it is not enough for the doctor to warn his patient to relax and be calm. *Active* measures are needed. In the past many experimental therapies have been attempted in hypertension. Yet to-day the treatment of choice can apparently still be summed up in two words: *Diuretics*, *Sedatives*. 'Tabloid' 'Theoba', combining as it does in one product the *diuretic* action of theobromine and the *sedative* action of phenobarbital supplies a convenient and satisfactory answer to the physician's problem.

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Theobromine gr. 5 (0.324 gm.)

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Provincial Notes

(*See also page* 64)

British Columbia

Citizens Launch Drive for Children's Hospital

Plans to build a $2,000,000 Children's Hospital with between 300 and 350 beds in the vicinity of Vancouver General Hospital have been launched by a citizens committee. Public support for half the cost will be sought and the Provincial government will be asked to subscribe the second million. Dr. Alan Brown of Toronto, authority on management of children's hospitals will advise the committee on the project. Emphasis has been placed upon the desirability of having the new hospital near the Vancouver General because of the development of a faculty of medicine at the University of British Columbia.

The Government recently earmarked $50,000 to help the present Crippled Children's Hospital and it is hoped that an additional $100,000 can be raised by subscription. This will fit into the scheme for the new hospital, it is held, and in time the Crippled Children's unit would become a convalescent home.

* * *

Women Appeal for New Infirmary at Marpole

The Women's Auxiliary of the Provincial Infirmary at Marpole has petitioned the Provincial Government for a new hospital. The present institution is badly overcrowded, the equipment is obsolete and the staff inadequate.

The auxiliary is asking for a 500-bed infirmary as an immediate minimum requirement. It would combine the population at Marpole, the 75-bed unit at Allso (a former relief camp), and the 100 beds now at Mount St. Mary Hospital in Victoria. It would also take in the patients who should be moved from other hospitals, from boarding houses and elsewhere from whom applications have had to be refused.

The auxiliary pictures single-storey buildings, with healthy ventilation and bathroom facilities, sunporches for cheer and health, and grounds for aesthetic satisfaction and morale.

Cheque for $40,000 Presented to Hospital Head

Denis Hagar, president of the Kiwanis Club, Victoria, B.C., recently presented to Dr. T. W. Walker, superintendent of the Royal Jubilee Hospital, a cheque for $40,000, proceeds of a campaign sponsored by the Club to obtain funds for the completion of the new maternity wing at the hospital. The presentation took place at a luncheon meeting of the Club in the Empress Hotel. A plaque of the Canadian Navy corvette Levis, the officers and men of which presented $500.00 to the fund, was also presented and will be hung in the new building.

The cost of the building is now estimated at $375,000, one third of which is being covered by the province, approximately one third by the city and municipalties and the remainder by public subscription.

* * *

President of Board Retires After Twenty Years

Mayor Herbert Clark has retired as president of the Trail-Tadanac Hospital Society after twenty years of service in that position. He remains on the board of directors and has assumed the post of vice-president. Mr. A. D. Turnbull of Tadanac has been named president.

* * *

Alberta

Provincial Grants Raised

The Provincial Government has agreed to increase the per patient day payment for tuberculosis patients from $2.50 to $3.00—an increase of $40,000 per year.

It has also agreed to increase the per patient day payment for obstetrical cases by fifty cents to all classes of hospitals. This means that Class A hospitals will receive a basic rate of $4.10 per day, plus 45 cents per day grant on behalf of the mother and 45 cents per day grant on behalf of the baby; a total of $5.00 per day on behalf of mother and baby. While it is the considered opinion of the executive that this increased rate will not meet costs, it is at least a step in the right direction. The increased rate will provide an additional $90,000 per year in revenue to member hospitals of the Associated Hospitals of Alberta.

* * *

Certificates of Service in the Hospital Field

In our democratic world, too frequently the persons who accept public responsibility receive little recognition and no thanks. As a gesture of encouragement, the Department of Health in Alberta presents a certificate of service to each person who has given twenty-five years as a member of a municipal hospital board. Twenty-five years in Alberta takes one back to the beginning of municipal hospitals in the province, so those who receive this certificate have pioneered in the administration of hospitalization on a municipal basis and have met the problems which are bound to arise in such pioneering.

Mr. George Weber of Drumheller was the first to receive a certificate, followed almost immediately by Mr. James Macdonald Taylor (now deceased) of Hanna and C. E. Thompson of Vermilion. Three more certificates are now due and will be presented shortly to Norman McClellan of Vermilion, G. E. Clay of Lloydminster and A. B. Wood of Islay.

* * *

Calgary Superintendent Chosen

Dr. J. D. Heaslip has been appointed superintendent of the Calgary General Hospital. Dr. Heaslip was formerly superintendent of the Ontario Reformatory.

* * *

Municipal Hospitals Increase

The future of the municipal hospital system in Alberta seems to be assured. The hospitals at Mayerthorpe, Oyen and Ponoka will be ready to open in the near future while a new hospital has been started at Two Hills and a new building will soon replace the old one at Consort.

This will give Alberta 42 hospitals operating under the Municipal Hospital Act and 12 more which are owned and operated by municipalities though not under the Act. This is a total of 54 municipal hospitals out of 100 hospitals in the province.

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Provincial Notes

(From page 60)

Saskatchewan

Shellbrook Opens Drive to Provide Hospital

The citizens of Shellbrook, Saskatchewan, have decided to form a hospital association under the C-Op. Societies Act, to be known as the Shellbrook Memorial Hospital Co-operative Association, with a minimum capital of $10,000. Committees have been appointed to organize a campaign. It is felt that to secure the services of a resident doctor a hospital or nursing home must be established immediately and it is proposed to convert the town hall into a 10-bed emergency hospital.

* * *

Manitoba

Judge George Heads Hospital Board Again

At the annual meeting of the Board of Trustees of the Freemason's Hospital at Morden, Judge J. M. George was once again unanimously elected chairman. During the evening Judge George spoke on the subject of hospital administration and the place of the hospital in the community. He pointed out that in rural areas such as their own, it was very important that each member of the board have a comprehensive knowledge of hospital management and become familiar with every branch of the hospital's activities. "The Board, therefore, should be composed of men who are prepared to devote sufficient time to that end or they cannot serve the institution efficiently". Referring to the election of officers, he emphasized the value of experience in this field and added, "Hospital boards, like individuals, however, do need new blood once in a while and a transfusion does very often help". Judge George is also Chairman of the Manitoba Hospital Council.

* * *

Grandview Plans Expansion

The Hospital of the Divine Child at Grandview is planning an expansion of its existing facilities. In preparation for their extended facilities two of the Sisters have left to take advanced courses in radiology and anaesthesia in the States. The hospital was opened in 1933 and has a bed capacity of 21.

* * *

Hamiota Hospital Elections

Mr. W. K. Fraser was elected chairman of the Board of Hamiota General Hospital with Mr. Gordon Killoh as vice-chairman. Mrs. R. O. Fraser heads the Ladies' Auxiliary. This hospital reported an increase of 232 per cent in its receipts from the Manitoba Hospital Service Association, from $611.00 for 1944 to $2,029.45 for 1945.

* * *

Shriners Plan New Hospital for Crippled Children

The Shriners Hospital for Crippled Children in Winnipeg, which has long been famous in Western Canada, has hitherto been housed in the Children's Hospital of that city. These quarters are now needed for other purposes, and the Shriners have completed plans for a separate hospital. They have tentatively chosen a site on Wellington Crescent. It is estimated that the sum of $150,000 will be required and hearty financial support has been pledged by cities, villages and municipalities all over the province.

* * *

Appointment at Brandon

Dr. Gladstone W. Fiddes of Ocean Falls, B.C., has been appointed medical superintendent and manager of the Brandon General Hospital. He succeeds Miss C. MacLeod, R.N., the former administrator.

* * *

Ontario

Hospital Head Retires After Fourteen Years

At the annual meeting of the Women's College Hospital, Toronto, Mrs. A. M. Huestis, fourteen years president and several years vice-president, announced her retirement. Mrs. Huestis remains a board member. In her address to the members she spoke of the proposed building program for the hospital which will include two new wings and a modern nurses' residence to house nurses now living in nine different buildings adjacent to the hospital. Mrs. Huestis also welcomed doctors and nurses returning from military service, including the former Major Dorothy A. Macham, the new superintendent who succeeds Miss Gertrude M. Watson, wartime superintendent. Miss Macham presented her first report as superintendent on this occasion.

* * *

Summer Lodge to Become Hospital at Southampton, Ontario

Hill Crest Lodge, formerly a summer hotel, is to become Suageen Memorial Hospital at Southampton. A campaign is under way and it is hoped that $50,000 will be raised shortly. The hospital, which will be the only one in Northern Bruce County, will have 21 beds, an operating room, delivery room, nursery, utility rooms and x-ray equipment, as well as staff and nurses' quarters.

* * *

New Ottawa Appointment

Dr. Allan R. Doane has been appointed superintendent of the Strathcona Isolation Hospital, Ottawa, and director of the venereal disease clinic of the Civic Hospital. After graduation from Dalhousie University in 1941, Dr. Doane took a diploma in public health at the University of Toronto and was then associated with the Ontario Department of Health as medical inspector of hospitals and in organizing medical service for civil servants.

* * *

New Memorial Hospital to be Built at Wiarton

The Bruce Peninsula and District Memorial Hospital will be located on the property of the old golf course at Wiarton and it is expected that construction will begin shortly. A committee, under Mr. Frank Watt, has been canvassing the district for this project and the original estimate of $50,000 has been far oversubscribed. The main part of the building will be two storeys high with two one-storey wings. It is planned to accommodate twenty patients.

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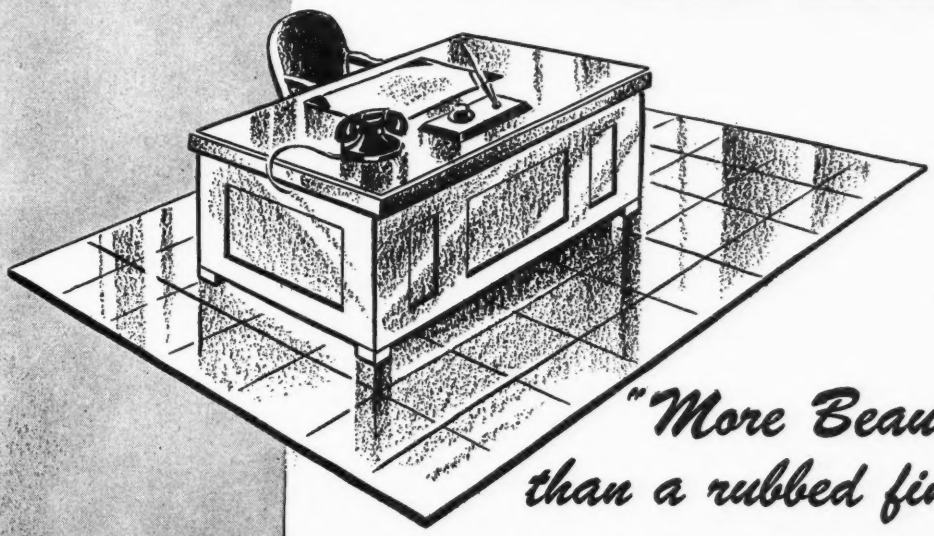

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Provincial Notes

(Concluded from page 64)

Ontario

Woodstock Hospital Trust Elects New President

On the occasion of the election of officers for 1946 at Woodstock, Ontario, the former president, Mr. T. L. Hay, relinquished the presidency, a post which he had held for six years. "It was a matter of policy", said Mr. Hay. "I believe that other members of the board will be more interested and learn more about the board and the hospital if they serve in the key office of president." The new president is Mr. E. J. Hosack.

* * *

Temporary Hospital Proposed at Brantford

The suggestion that Winston Hall, wartime residence for industrial employees, be purchased by the city of Brantford and converted into temporary hospital accommodation has been warmly approved by the members of the Hospital Board. This building which has been closed by the Federal authorities can be purchased for $32,000 and would provide badly needed ward space, especailly suitable for convalescent or chronic patients. At the same time plans are under way for the construction of a new hospital unit to accommodate approximately 120 patients. A new power plant, a dietary department, and a nurses' residence will be included. The present nurses' residence will be converted into a home for convalescents. A total expenditure of close to $1,400,000 has been estimated and it will be at least a year or two before the project can be started. For the present, the purchase of Winston Hall appeals to the Board as a solution.

* * *

Quebec

Cities May Meet Deficit of Alexandra Hospital

The City Executive Committee has approved in principle a proposed arrangement with the Alexandra Hospital under which Montreal, Outremont, Westmount and Verdun will contribute annually to the hospital's deficit, provided this does not exceed $50,000. A main provision of the agreement which is being drawn up is that the hospital will maintain beds for 50 tubercular patients, preferably children. The City of Montreal will cover a further bill for as high as $20,000 for changes in building and equipment for this purpose. It is believed that the four cities will contribute each year to the deficit according to population.

* * *

$400,000 Grant to Sherbrooke Hospital

The Provincial Government of Quebec has decided to make a donation of $400,000 to the Sherbrooke Hospital, to aid in the construction of a modern institution in the North Ward of that city. With the sale of the existing property, the sum of $350,000 will still be required to finance the new building and this is to be raised by public subscription. Sherbrooke Hospital serves the English-speaking residents of that section of the Eastern Townships.

* * *

Maritimes

Maritime Plan Seeks Incorporation in N.B.

Notice has been given that at the 1946 session of the New Brunswick legislature application is to be made for an Act to re-incorporate in New Brunswick the Maritime Hospital Service Association. This would then permit the Association to enter into reciprocal agreements with other hospital service plans carrying on business outside the Maritime Provinces; would protect the use by the Association of the name "Blue Cross"; and would permit the Association to contribute out of its funds to a pension plan for its employees.

* * *

Superintendent Appointed at Woodstock, N.B.

Miss Mary Ingham of Toronto has been appointed Superintendent of the L. P. Fisher Memorial Hospital, Woodstock, N.B. Miss Ingham is a graduate of the McGill School of Nursing and previously held positions in Toronto and Moose Jaw.

Ontario Blue Cross Sets Up Special Plan in Listowel

The Plan for Hospital Care in Ontario, which is a group plan, has set up a special community arrangement for Listowel. The regular group plan prevails as elsewhere but once a year individuals, with or without dependents, may enrol as individuals.

Subscribers receive up to 21 days of hospital care in a general ward, plus extras (operating room, anaesthesia material, routine laboratory tests, ordinary drugs, dressings, etc.) up to $25.00 per admission and have the option of semi-private or private accommodation in which case a $3.00 per day allowance is made. Benefits for enrolled dependents include one half of subscriber benefits up to 21 days for wife and each child under 16 years of age. Conditions arising from pregnancy are included if enrolled for 12 or more consecutive months. Extra services for dependents include one half of charges up to $12.50 for each admission. The rate for single subscribers is $8.00 per annum, and $14.00 for the subscriber, spouse and children under sixteen years of age.

Individual enrolment was opened during the latter part of February.

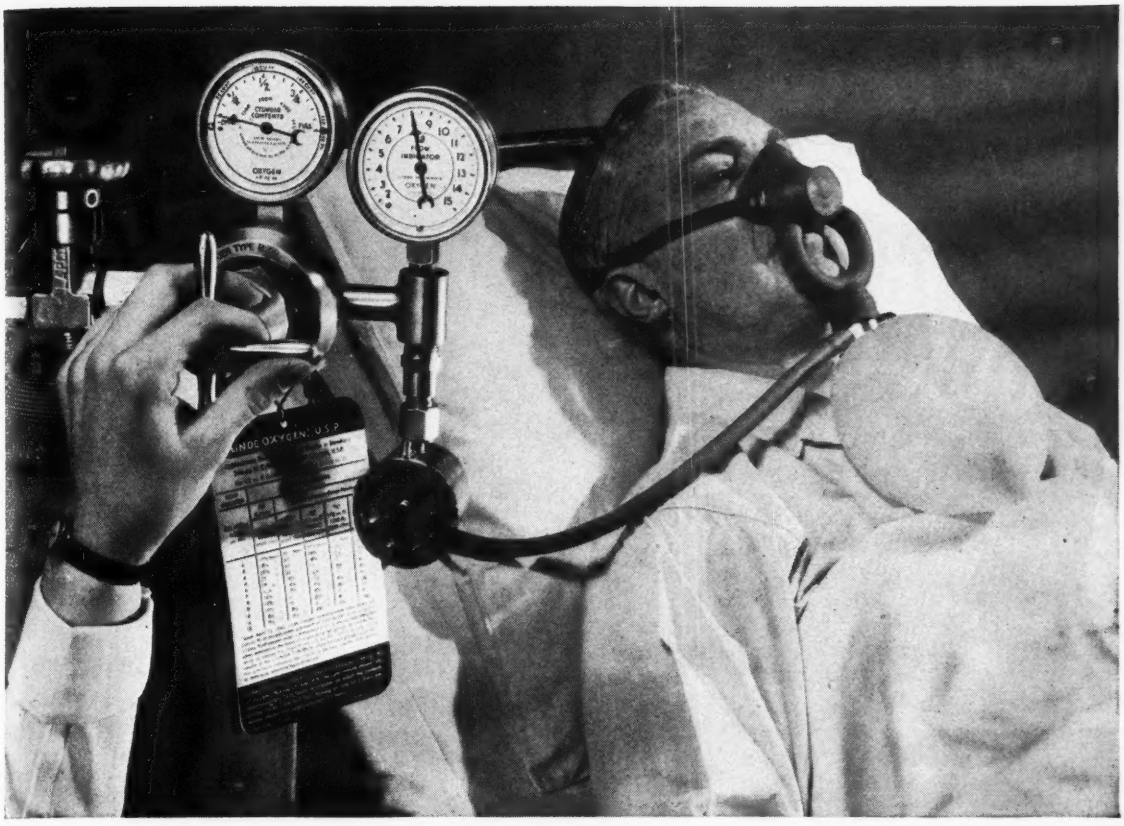
In many respects the Listowel arrangement is similar to that in operation in Kingston. Listowel and Kingston were two centres with individual enrolment plans antedating the setting up of the province-wide group plan.

* * * *

The Plan for Hospital Care (Ontario) increased its enrolment by 18,755 in February. As of March 1, the number of participants was 571,986.

Manuscripts Invited For Norton Medical Award

The book publishing firm of W. W. Norton & Company announce that they are again inviting manuscripts for submission to be considered for the Norton Medical Award of $3,500 offered to encourage the writing of books on medicine and the medical profession for the layman. Closing date for submission of manuscripts this year is November 1st, 1946. All particulars relating to requirements and terms may be had by addressing W. W. Norton & Company Inc., 70 Fifth Avenue, New York 11, N.Y.



Time To Order Up Another Cylinder

When *continuous* oxygen has been prescribed, as in the treatment of congestive heart failure, interruption of treatment is apt to result in recurrence of symptoms.* To safeguard against interruption, it is good practice to establish an order point on the oxygen for each patient so that a replacement cylinder is ready well before the cylinder in use is empty.

At an oxygen flow of 8 liters per minute, for example, the 500 liters remaining in the cylinder, as indicated on the regulator above, will last for approximately one hour. It is time, therefore, to order up a replacement cylinder. The continuous oxygen supply thus provided helps to assure effective oxygen therapy.

A pocket-size Dominion Oxygen flow chart tag which shows how long the oxygen in a cylinder will last at flows of from 2 to 15 liters per minute will be sent without charge, on request.

*References to the medical literature will be sent on request.

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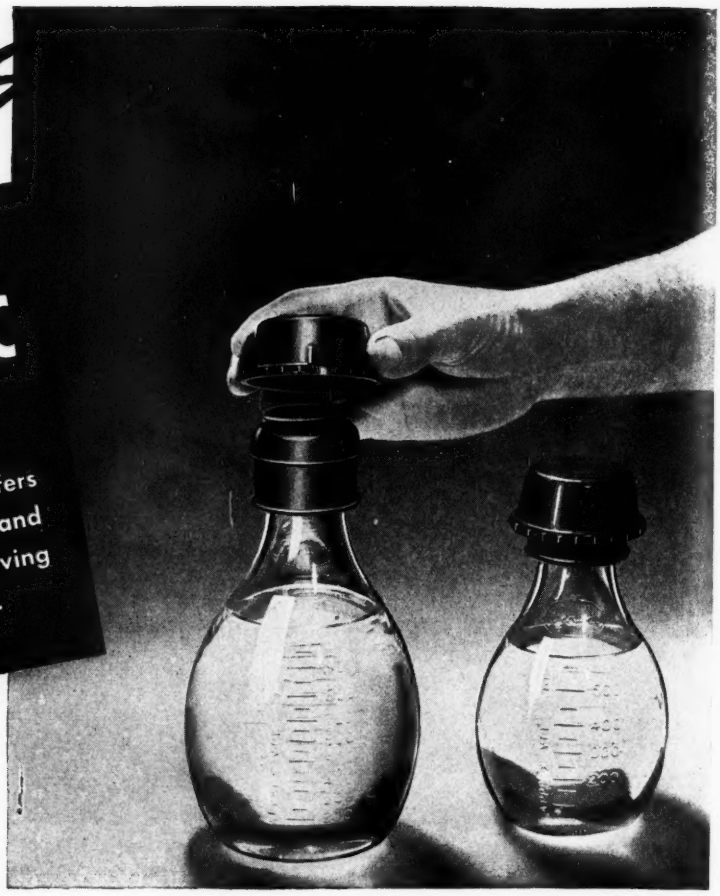

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The flaring upper lip of the collar facilitates pouring solutions directly from the original container without danger of contamination by contact with parts of the collar which are not within the sterile area of the closure. Contents will pour freely and without drip.

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From "Measuring the Community for a Hospital", prepared for the American Hospital Association by Warren P. Morrill, M.D. its director of research.

THE number and type of specialists required to staff a hospital sufficiently to give relatively good service to its patients is variable. The three basic specialties which should always be represented are internal medicine, surgery and obstetrics.

The services of the general practitioner are largely in the field of internal medicine. While it is probable that a community of 10,000 or so could use the services of a specialist in internal medicine or a "diagnostician" as he is commonly called, to the benefit of its people, it is probable that it would take a community of two or three times that size to justify a competent internist in preparing himself and limiting his practice to this specialty.

It is probable that there is enough surgery in a community of 10,000 population to justify the services of a fully qualified surgeon, particularly if the hospital adheres to the policy described by Dr. Malcolm T. MacEachern, Associate Director of the American College of Surgeons:

"The restricting of privileges to do major surgery to those who are qualified is most essential, and this protection for the patient is provided in the approved hospital. The approved hospital has a definite standard of training, experience and competency, and a qualifications committee of the surgical staff which determines who is and who is not qualified to do major surgery.

"It is a growing custom for hospitals to limit appointments of heads of departments of the medical staff to Fellows of the American College of Physicians, Fellows of the American College of Surgeons, and diplomates of the respective American Boards for the various specialties. Such a provision assures a higher quality of clinical work and better supervision and control of the professional activities of the institution."*

The majority of patients enter the hospital to take advantage of its surgical facilities and it is, therefore, the surgeon who is in most demand.

While the large majority of maternity cases fare well at the hands of the general practitioner, the demand for skilled obstetricians is rapidly increasing. In view of all the elements entering into the question it is probable that a community of 15,000 to 20,000 is necessary to attract and support a fully qualified obstetrician.

Other basic specialties are women's surgery, children's diseases and diseases of the ear, nose and throat. Women's surgery in the small community is usually handled by either the general surgeon or by the obstetrician. Children's diseases can usually be adequately cared for by the internist. Patients having diseases of the ear, nose and throat are usually ambulatory, but are so common that a community of 15,000 or so will usually be sufficient to attract and support a qualified specialist.

Experience indicates that one roentgenologist can properly serve some 60,000 of population and a pathologist some 100,000. It has been shown that if each individual hospital is supplied with good technicians, the roentgenologist and the pathologist can serve several small hospitals by working on a "circuit rider" basis.

A community of 20,000 to 25,000 population could expect to have 18 to 20 active practitioners of whom 3 to 5 would be qualified specialists —an internist, a surgeon (possibly two), an ear, nose and throat specialist and an obstetrician. While such a community could support a hospital of 75 to 100 beds, it would still be necessary to have some sort of an affiliation with some larger community for professional service in the more limited specialties.

This does not mean, however, that the smaller community must be de-

(Concluded on page 90)

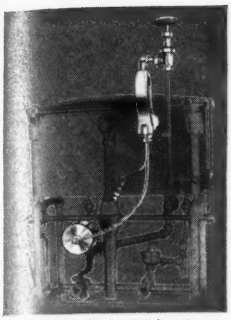
In Canada, consideration might well be given to insistence upon one of the English or Edinburgh higher degrees, upon fellowship in the Royal College of Physicians and Surgeons of Canada, or as indicated above, the F.A.C.S. or F.A.C.P. degree. Under any circumstances, except possibly in quite small hospitals, the heads of major or specialty departments should hold the specialist's certificate issued by the R.C.P.S. (C).

Montreal Hospital Re-Named Herbert Reddy Memorial Hospital

The Woman's General Hospital of Montreal has been re-named the Herbert Reddy Memorial Hospital in tribute to the late Dr. Herbert Lionel Reddy, B.A., M.D., C.M., L.R.C.P., former superintendent and staff member of the hospital. The name "Woman's General" has been misleading as male patients have been admitted since 1941 and now comprise some 40 per cent of the patients. At present men are admitted to private and semi-private rooms and male wards and clinics are under consideration.

Dr. Reddy, born in Montreal in 1854, graduated from McGill in arts, '73, and in medicine, '76. Later he interned at St. Thomas' Hospital and in Vienna, taking his L.S.A. and his L.R.C.P. in London and his L.R.C.S. in Edinburgh. When he joined the staff of the Woman's General Hospital it was a very small hospital. He was its first superintendent when it moved to its present site on Tupper Street and observed the 50th anniversary of his connection with the hospital just a few days before his death.

Authority for this change of name was given by the Quebec Legislature last month. Mr. H. C. Allnutt is the present superintendent of this 153-bed hospital.



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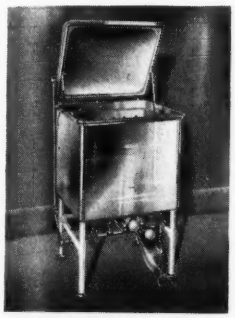
The Vent-O-Stat operates by means of a sensitive thermal element placed in the water supply air break fitting, at the back of the sterilizer, which controls the heat input according to the temperature of the vapor formed within the sterilizer. When the water in the sterilizer is below the boiling point, the control admits full heat to the sterilizer. As the water starts to boil, some of the steam passes out to the atmosphere through the air break opening on the water fill fitting, heats the thermal element and shuts off the main supply of heat. A bypass then permits enough heat to pass to keep the water in the sterilizer at the boiling point without formation of excess waste steam. When so specified the sterilizers described below can be equipped with the Vent-O-Stat.

Steam heated instrument sterilizer.

INSTRUMENT STERILIZERS

The Scanlan-Morris instrument sterilizers illustrated are made in four sizes—body and cover of monel or plated copper. The raising and lowering mechanism for simultaneously opening cover, elevating and lowering instrument trays, and closing cover, is operated by foot pedal. An oil check pump makes the lowering of cover and trays noiseless. The two larger size sterilizers are provided with one full size tray and two half size trays. The two smaller sizes have one full size tray only. Tubular steel stands are white enameled with plated brass adjustable floor plates.

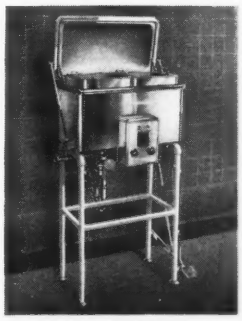


Steam heated utensil sterilizer.

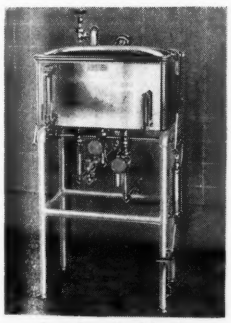
UTENSIL STERILIZERS

The Scanlan-Morris utensil sterilizers illustrated are made in three sizes. Construction and finish is similar to that of the instrument sterilizers except trays which are full deep size, with guide rollers for easy raising and lowering.

When so specified any of these instrument and utensil sterilizers can be mounted on wall brackets in place of floor stands, and can be equipped with the Vent-O-Stat.



Electrically heated instrument sterilizer.



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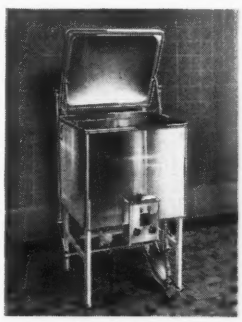
The Scanlan-Morris sterilizer shown at the left is an efficient, durable, simple type of pasteurizing apparatus that insures the perfect pasteurization of milk, and can be used for the sterilization of the milk bottles. Made in various sizes and types. When specified, the sterilizer can be equipped with Vent-O-Stat heat control for regulating the rate of boiling and eliminating excess steam.

For detailed information on the Vent-O-Stat and on non-pressure sterilizers, or high pressure sterilizers, including recessed autoclave and water sterilizer installations, mail the coupon below.



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$600,000 for Cancer Research Left to University of Toronto

Thomas Fostor, eccentric former Toronto mayor who died recently at the age of 93, left $600,000 as a trust fund to the University of Toronto to be used in cancer research. After the cause of cancer will have been discovered the fund is to go to the Canadian Medical Association for the improvement of medical care in rural areas.

Mr. Foster was three times mayor of Toronto and was noted during his long years of service on the City Council and the Board of Control as the "Watchdog of the Treasury". No matter what the proposed expenditure, "Honest Tom" was opposed, a policy which gave him tremendous support from the taxpayers. Some years ago he erected, at considerable cost, an elaborate memorial and mausoleum for himself at Uxbridge, Ontario, and in his will he left $80,000 for its maintenance.

His will, disposing of some $1,168,555, had many unusual features and covered a wide range of bequests. Of particular interest to the hospital field, aside from his gift for cancer research, was his contribution of $25,000 for a ward in a Toronto hospital exclusively for consumptives; for the present the ward being maintained at the Toronto Hospital, Weston. There is to be also a $10,000 trust for the Queen Elizabeth Hospital for Incurables, $10,000 forms a fund to provide motor drives, movies, radios and other entertainment at this hospital and $5,000 is to be divided among ten patients in this hospital who have no other sources of income. They may spend the money as they wish.

Much publicity has been given to the four "Stork Derbies" which he has provided for. Ten thousand dollars will be spent in four 10-year time divisions. The income from $100,000 is to be used for annual picnics for Toronto children, provided the Mayor or a prominent clergyman gives an address referring to Mr. Foster. Charwomen and newsboys were assisted. Prizes are offered for memorizing scripture in his old church. Money is made available to feed wild birds during the winter. A fund of $100,000 is to provide trees along highways leading into the city. He left $3,500 for the purchase of a flagpole for one of the technical schools. He left funds for the erection of a Northern Ontario mission for the United Church and one for the Anglican Church.

American College of Physicians Announces Graduate Courses

A final bulletin of postgraduate courses as arranged by the American College of Physicians has been received. These courses are primarily for fellows and associates of the College but are open to non-members, preference being given to (a) candidates for membership; (b) medical officers; (c) physicians preparing for Certification Board examinations; and (d) other non-members having adequate background for advanced work.

Ten courses are announced; these being in clinical allergy, general medicine (3), internal medicine (2), metabolism and nutrition, gastro-enterology, cardiology and thoracic diseases. Various hospitals are co-operating, such as the Massachusetts General Hospital, Jefferson Medical College, University of Texas, Hillman Hospital, Birmingham, Alabama, Emory University, Atlanta, the Graduate Hospital, the Philadelphia General Hospital and the Woman's Medical College of Philadelphia, the University of Michigan and the University of California.

Registration is limited and varies with the individual course. Duration of the courses is from one to three weeks, ranging through April to July. Fees vary according to the course and special consideration is given to medical officers in uniform.

The Educational Director of the College is C. C. Shaw, 4200 Pine Street, Philadelphia 4.

A.C.S. Holds Helpful Regional Conferences

Last month two Regional Conferences of the American College of Surgeons drew a large attendance of surgeons and administrators.

The Montreal meeting dealt with the development of the post-war hospital and elicited some fine addresses dealing with the subject from several angles. Standards of administration were considered by Dr. A. L. C. Gilday, superintendent of the Western Division, Montreal General Hospital; Dr. John C. Mackenzie, hospital consultant; Dr. M. T. MacEachern; Dr. Harvey Agnew; Mr. A. H. Westbury, chief accountant, Montreal General Hospital; and Dr. John R. Fraser, Montreal, Regent of the College. Addresses on professional services were given by Dr. Edmond Dubé, professor of surgery, University of Montreal; Dr. W. D. Piercey, superintendent, Ottawa Civic Hospital; Dr. J. E. de Belle, superintendent, Children's Memorial Hospital, Montreal; Dr. Harold Griffith, superintendent, Homoepathic Hospital; Miss Gertrude Hall, Reg. N., general secretary, Canadian Nurses Association; Miss Margaret S. McCready, Director, School of Household Science at McGill; and Mr. H. C. Allnutt, superintendent, Herbert Reddy Memorial Hospital, Montreal.

The latest developments in the care of various types of patients were reviewed by Mr. John Hornal, superintendent, Civic Hospital, Peterborough; Dr. R. P. Vivian, professor of Health and Social Medicine at McGill; Miss Sara P. Tansey, superintendent, Montreal Convalescent Hospital; Dr. Hugh E. Burke, medical director, Royal Edward Laurentian Hospital; Dr. J.-Ed. Samson, chief in orthopaedics, Sacred Heart Hospital and Dr. Newell W. Philpott, professor of obstetrics and gynaecology at McGill University.

Stimulating luncheon addresses were given by Dr. Frank H. Lahey, of Boston and Dr. R. P. Vivian of Montreal. Excellent technical films were shown at stated intervals and the Hospital Conference ended with an all-afternoon Round Table led by Dr. Agnew with the assistance of a coterie of experts.

The Detroit meeting was arranged along similar lines with, we understand, a number of contributors from Western Ontario.

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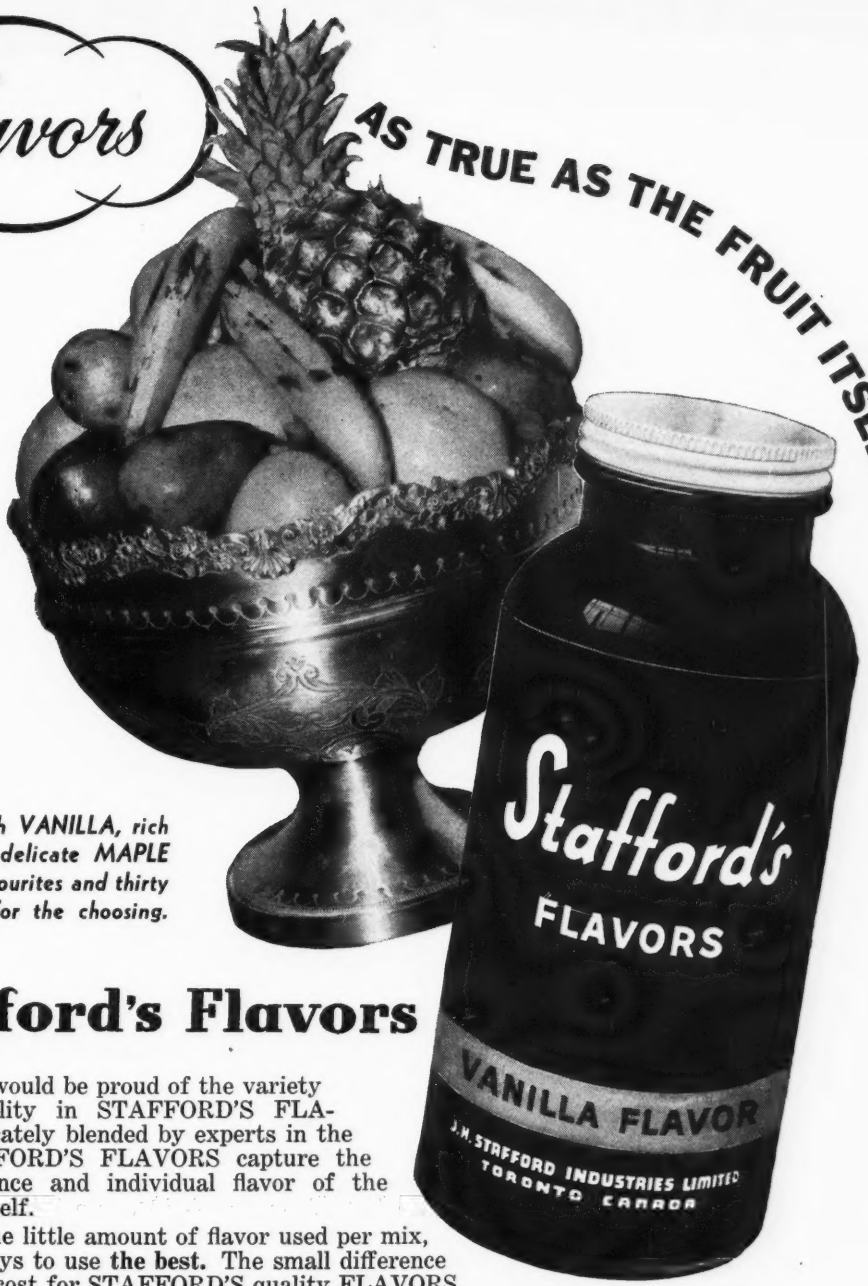

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A.H.A. Retirement Plan

for Hospital Employees

AT the annual meeting of the American Hospital Association in 1944 a Pension Committee was appointed to study and make recommendations concerning the provision of a retirement plan for hospital employees. Much progress has been made in the interval.

Coverage under the Federal Social Security program in the United States is not now available to the employees of non-profit organizations and it was felt that some form of pension plan for hospital employees would help to establish good employer-employee relations and enable the hospitals to compete with private industry in the labour market.

A questionnaire was sent out to determine the attitude of member hospitals toward this problem and the results indicated a wide-spread desire that the Committee prepare a program which would be available to hospitals both large and small. It was generally agreed that any pension plan which might be developed should make provision for the eventual amendment of the Social Security Act to include non-profit hospitals and for concomitant reductions in contributions, but it was felt that hospitals, even if eventually covered by Social Security, should provide a supplementary pension program for their employees, particularly the professional and administrative groups. It was the opinion of those studying the problem that the cost of such a hospital plan should be regarded as a necessary operating expense and at least a part, if not all, of the additional expense should be covered by an adjustment in the hospital rates.

Mr. Homer Wickenden, Secretary of the National Health and Welfare Retirement Association discussed at length the basic features of that plan with the members of the Committee. The N.H. & W.R.A. is a successful organization developed by Community Chests and Councils, Inc., after six years of study. The Committee also considered the provisions of the plan being adopted by the Cleveland Hospital Council, the plan of the Methodist Hospital in Indianapolis and that of the Presbyterian Hospital in New York City.

The plan eventually outlined by the Committee incorporated certain features of all these but is substantially identical with the N.H. & W. R. A. system. For this reason, it seemed feasible and least expensive to have the A.H.A. plan operated through the existing facilities and personnel of the N.H. & W.R.A. It was recommended, therefore, by the Committee "that a separate corporation should be organized as quickly as possible under Section 200 of the New York State Insurance Law, to be known as the 'American Hospital Retirement Association, Inc.', to be operated by and in conjunction with the National Health and Welfare Retirement Association, Inc., and to be under the supervision of its own representative Board of Trustees and Executive Committee".

The Plan

The principal provisions of the proposed plan may be summarized as follows:

Eligibility. Regular employees of a non-profit hospital are eligible after one year of service if between 25 and 65 years of age. Membership is a condition of employment after the plan has been adopted by the hospital.

Retirement age. Employees will retire at 65, or three years after effective date of plan, whichever is later. They may retire at a reduced benefit within ten years of that age. They may remain in service after that age, receiving both salary and retirement benefit.

Contributions. Each employee will contribute 3 per cent of regular earnings while the hospital adds 5 per cent of such earnings. It is recommended that the value of maintenance be included as a part of regular earnings where possible, although this is not mandatory.

Benefits for Future Service. The sum of the above contributions (after deduction of administrative costs not exceeding 4 per cent of contributions) will be applied to provide retirement benefits. The amount of benefit purchased will depend upon age and sex of employee, amount of contributions to be applied and the rates then in effect.

Benefit for Past Service. It is recommended that hospitals include benefits based on the employee's years of service prior to the date on which the plan is adopted. The minimum amount of such benefits would be ½ of 1 per cent of the employee's earnings at that date multiplied by the years of regular service since his 35th birthday. Hospitals pay the entire cost of this benefit.

Death Benefits. At death before benefits commence, the employee's total contributions with 2 per cent compound interest are paid to his beneficiary. At death after benefits commence any excess of total contributions with 2 per cent compound interest to date of retirement are paid.

Termination of Employment. Employee may elect to receive his total contribution plus 2 per cent compound interest in a cash payment or the retirement benefit provided by his own and his employer's contributions at normal retirement date. The second option is available only if the benefit would amount to $40.00 per year. If the employee transfers to another employer covered by the plan, his employment will not be considered as having terminated.

Optional Forms of Benefit. Employees may choose other forms of retirement benefit, including an option

(Concluded on page 96)

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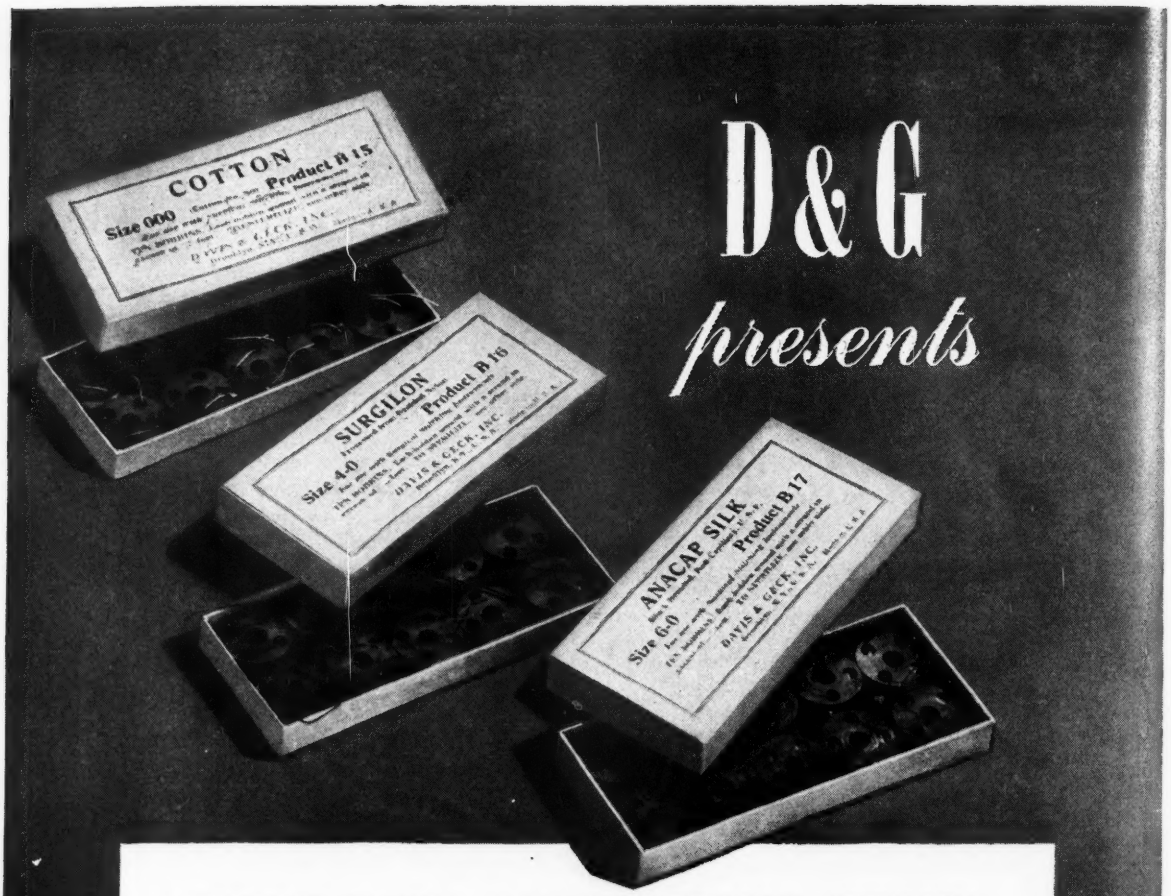

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Book Reviews

PATTEE'S DIETETICS by Alida Frances Pattee, revised by Hazel Munsell, Ph.D. and others. Twenty-third Edition. 736 pages. Illustrated. Price $3.75. Published by G. P. Putnam's Sons, New York. Canadian Agents—McAinsh & Co. Ltd., Toronto. 1945.

This revised edition of a standard text is designed to present the material, now brought up-to-date, in such a way that the relation of the theory and practice of diet therapy to our concepts of normal nutrition is readily apparent, thus increasing its value to dietitians and nurses. The section on *Nutrition* has been entirely rewritten in order to incorporate new findings in nutrition research. Tables of food composition have been revised to include the most recent material compiled by the United States Department of Agriculture and the National Research Council Committee on Food Composition and many new tables for special foods or food groups are given throughout the book. Values for protein, fat, carbohydrate and energy value are given for each recipe. Many of the chapters under *Diet Therapy* have been written by specialists in the particular phase of the subject covered and several new tables have been added. The section on *Foods and Food Preparation* has been rewritten and the description of foods and methods of cookery have been brought up to date.

* * *

HEALTH CARE OF THE FAMILY. By Ramona L. Todd, M.D., Assistant Professor, School of Public Health, University of Minnesota and Ruth B. Freeman, Reg. N., M.A., Associate Professor and Director of the Course in Public Health Nursing, School of Public Health, University of Minnesota. Pp. 530, illust. Price $3.50. W. B. Saunders Company, Philadelphia & London, McAinsh and Co. Limited, Toronto. 1946.

This volume is based upon the sound premise that "while much can be done through appropriate community action for health protection, the extent to which national health is achieved will depend in large measure upon the daily health care afforded within the family group".

The practical preventive and remedial measures of health care are emphasized, although in every case sufficient theoretical knowledge is prefaced to make the suggestions understandable. A helpful section on procedures for the home care of the sick is included. Prevention rather than treatment is stressed throughout, and fundamentals such as good food, sufficient rest, emotional tranquillity, etc., are never subordinated to regimes to drug dosages.

* * * *

A CONCISE PHARMACOLOGY AND THERAPEUTICS OF THE MORE IMPORTANT DRUGS, TOGETHER WITH AN INTRODUCTION TO THE ART OF PRESCRIBING. By F. G. Hobart and C. Melton, with a foreword by Sir Adolphe Abrahams. Pp 162. Leonard Hill Limited, London. Second Edition 1944.

This little book of some one hundred and sixty pages contains an amazing amount of information useful to the student and physician, while for the benefit of the older practitioner it discusses action and uses of many drugs long in use. It contains in concise form much information about the newer drugs which are used so extensively.

—G. H. W. Lucas

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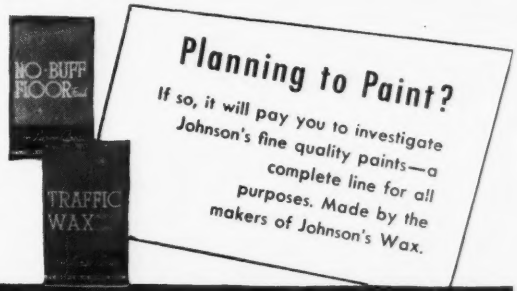

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Correspondence

Hospital Administration Course at Columbia Described

Dear Mr. Editor:

You may be interested in obtaining further information about the course in hospital administration at Columbia University here in New York.

This course is of twenty months' duration—eight months in residence and one year of administrative assistantship in an approved hospital—and leads to the M.Sc. degree. Both sexes are accepted and all applicants must have a degree—M.D., B.A., or B.Sc. Evidence of personal capability and fitness for hospital administration is essential.

The present class, all ex-service personnel, consists of twenty-two men and two women. Six are physicians. I am the lone Canadian.

The university work consists of lectures, seminars, assigned reading, demonstrations, and visits to city and state hospitals. The following phases of hospital administration are covered thoroughly: organization, administration, personnel, finance, purchasing, plant maintenance, records, etc.; the allied fields of public health, social service and welfare, health education, public relations, etc., are not forgotten.

The staff, under the professorship of Dr. Claude Munger, director of St. Luke's Hospital, and his full-time assistant Dr. John Gorrell, is composed of part-time lecturers from outstanding hospitals in the city and state, each instructor an experienced, capable leader in his own branch.

The course is well balanced, all-inclusive, conducted on a post-graduate level and well worthy of serious consideration by those interested in hospital administration.

Yours sincerely,

"J. G. Turner, M.D."

(Dr. Turner is from Fredericton, N.B., and graduated at McGill in '32, after which he interned at the Hamilton General Hospital. He practised in Fredericton before enlisting with the R.C.A.F. where he had command of various hospitals. At the time of his discharge Wing-Commander Turner was Principal Medical Officer, Eastern Air Command.)

Coming Conventions

April 12-13—B.C. and Pacific States Conference, A.C.S., Multnowah Hotel, Portland.
May 6-18—Canadian Public Health Association, Royal York Hotel, Toronto.
June 10-13—Catholic Hospital Association, Milwaukee.
June 10-14—Canadian Medical Association, Banff Springs Hotel, Banff, Alberta.
July 1-4—Canadian Nurses Association, Toronto.
September 30-October 4—American Hospital Association, Philadelphia.
October 21-23—Ontario Hospital Association, Royal York Hotel, Toronto.
October 28-November 2—Institute on Administration and Convention, Manitoba Hospital Association.
November 5-6—Saskatchewan Hospital Association, Saskatoon.
November 12-15—British Columbia Hospitals Association, Vancouver.

Population in Britain

MOST people are aware that since the 1870's the birth-rate has been on the decline, but a continued growth of total popualtion during this period has tended to mask the full implications of the situation, and the unexpected rise of the birth-rate in 1942-44 further contributed to lessen serious concern. Any bubble of complacency, however, arising from hopes of the permanency of this war-time rise should be pricked by the recently published figures for the quarter ended September 30, 1945. Both for England and Wales and for Scotland these show that the rate has again begun to decline.

To the housewife who spends half her time in shop queues and the rest of us who queue for trains and buses and the mid-day meal, this continued fall in the birth-rate may seem no bad thing. Most of us at some time or another have passing thoughts of a world with rather less people and a greater share of amenities, rewards, and security for each. It is nice to think of a stable population of, say, some ten millions less than our present one, with a nicely balanced proportion of old to young, but alas the realities of the situation rudely shatter such day dreams.

The cold facts are that although the total poulation is not yet on the decline the ratio of old to young people is rapidly rising, and fewer young people mean fewer potential parents. Every year now Britain has 100,000 fewer persons under twenty than during the previous one, while the number of the old increases. As the recent P.E.P. broadsheet (vital statistics) points out, if present trends continue the population of Britain may well be reduced to 29 millions by the end of this century, and to some 14 millions by 2039.

There is therefore, as things stand at the moment, no question of a gradual and comfortable decline to the small stable population which we are apt to conjure up. Once started, a population decline is in the nature of a snowball, ever enlarging and accelerating, with an increasing series of economic malajustments as the natural concomitant. As *The Lancet* recently put it, it is academic to talk about the ideal population size for Britain. The choice before us is either that of ignoring the situation, with the results noted above, or of attempting by all possible means to stabilize our population at about the present figure.

To do this is not going to be easy. The size of a modern society is now dependent not on "nature" but on the conscious decisions of its adult citizens. These decisions can be influenced by the social and economic measures taken to make parenthood attractive, but they are equally influenced by the general state of society in which people find themselves living, and the degree to which they feel active confidence in it. To quote P.E.P.'s second broadsheet on the subject ("Retreat from Parenthood") "it will be the test of a progressive society whether or not the conditions of life which it offers to its citizens are such as to command this confidence and make for a set of values in which parenthood ranks high".

From "The Hospital", February, 1946.

Dr. G. B. Chisholm Named to UNO Committee

Dr. G. B. Chisholm, Deputy Minister of National Health, has been appointed to the technical preparatory committee to plan an international health conference, the Hon. Brooke Claxton has announced.

Calling of a conference to establish an international health organization was first suggested by the Brazilian and Chinese delegations, with Canadian support, at the San Francisco conference early last summer. The technical preparatory committee was set up by the Economic and Social Council of the United Nations and is meeting in Paris.

Jon Jonkel Now Consultant in Hospital Public Relations

Mr. Jon M. Jonkel, who has been director of the Department of Public Relations and secretary of the Council on Public Relations of the America Hospital Association, has resigned to establish an organization specializing in the public relations problems confronting hospitals. He will offer assistance in the public relations programmes of individual hospitals and is prepared to serve as a public relations consultant in fund-raising campaigns. He is prepared to make public opinion surveys, make an audit of the hospital's work that has a bearing upon public opinion, and prepare public and employee education programmes. Mr. Jonkel will be located in Chicago and will have the advantage, not only of his work with the A.H.A., but his previous experience as a public relations consultant.

Should Establish Centre for Mentally-Ill Infants

The National Committee for Mental Hygiene is urging that a centre be established which would take over the care of mentally defective infants as soon as it becomes apparent that they cannot develop, and thereby relieve the family of a responsibility which places all members at a serious disadvantage.

Such a project should be undertaken through private auspices rather than the Provincial Governments, stated Dr. Brian Bird, a member of the Committee, although the Governments should accept financial responsibility at a per diem rate, and should agree "formally to accept these children in a Government training school when and if they reach the age of six years".

What Size Community?

(Concluded from page 72)

nied at least limited hospital facilities. All it means is that the physical facilities provided should be limited to those which the available staff is qualified to use to the best interests of the patients. A community as small as 8,000 to 10,000 can support a hospital of 25 to 35 beds and can usually assemble a staff of sufficient qualifications to give adequate care to perhaps 90 to 95% of patients. But this type of hospital does impose added obligations on the governing board since this board is responsible for the adequate care of the patients and must make and enforce regulations to provide for consultations with better qualified specialists or even transfer to hospitals having better qualified specialists and more complete facilities for patients whose condition requires such highly specialized care.

Major Causes of Death

The American Public Health Association has issued a list of the major causes of death in 1945:

1. Heart disease
2. Cancers and other malignant tumors
3. Intracranial lesions of vascular origin
4. Nephritis
5. Pneumonia
6. Accidents other than from motor vehicles
7. Tuberculosis

Russian Institute of Defectology

Seven years ago a special scientific centre was organized in Russia for the study of defective children, which in 1944 became a scientific research institute of the Academy of Pedagogical Sciences. The institute's work consists of perfecting methods of developing positive talents and abilities in defective children, finding methods to overcome or lessen their defects, and in training them to become adults capable of finding a useful vocation in life.

A Modern ISOTONIC COLLYRIUM

MURINE is a buffered, isotonic solution, and can be used without fear of irritation to the conjunctiva or cornea. The pH of the Murine formula, approximately 8.0, together with the isotonicity of the tears, fulfills all the more modern desiderata of a collyrium in that it is soothing, cleansing, and non-irritating.

The ingredients contained in the Murine formula are: Potassium Bicarbonate, Potassium Borate, Boric Acid, Berberine Hydrochloride, Glycerine, Hydrastine Hydrochloride 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) .001%, combined with Sterilized Water.

Boric Acid is advantageously used in a low concentration (1.4830). A higher percentage, in combination with the other salts present, would cause Murine to be hypertonic to the eye and therefore lose its soothing effect and produce symptoms of mild congestion and irritation.

The ingredients, Potassium Borate and Potassium Bicarbonate, are mildly alkaline and serve as a detergent and mild astringent. They act synergistically with Boric Acid, which is mildly antiseptic.

Glycerine is used for two specific purposes: 1—it adjusts the Murine solution to the exact isotonicity of the tears: 2—it keeps the conjunctiva moist.

Berberine serves a very useful purpose. It has been known for many years that the alkaloid Berberine in alkaline solutions is an effective therapeutic astringent on inflamed and catarrhal conditions of the mucous membrane. The therapeutic effect of Berberine on mucous membrane is supplemented by Hydrastine Hydrochloride. To the above, a 1% solution of 1-1000 of 'Merthiolate' is added since it was found by practical experimental research in our laboratory that this solution was sufficient to inhibit mold growth.

The method of compounding these previously mentioned ingredients eliminates all side reactions together with the formation of any unlooked-for chemical realignments, thereby guaranteeing the true and unadulterated percentages of the formula as a final product.

THE FORMULA OF MURINE is in keeping with the dictates of all the recent desirable factors necessary in a collyrium: it is isotonic with the tears, it is a truly buffered solution, it includes mild but effective astringents, and a preservative. This all makes for a soothing, cleansing, and still uniquely therapeutically effective preparation for minor irritations of the eye.

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Australian Pension Plan Elicits Quick Response

Nearly a million pounds' worth of business has been written up in two months in the superannuation scheme which has been established by the Charities Board of Victoria for institutional staffs.

The Institutional Staff Superannuation Fund provides benefits by means of policies of insurance on the lives of the employees. Retiring age is 65, or 60 for females. The employee contributes approximately 3½ per cent of salary, and the employing institution pays in 3½ per cent. Beginning at the lowest weekly wage the contributions start at one shilling, twopence a week for a junior and the same amount is paid by the employer up to 7s. 6d. each from employee and employer to a wage of £10 5s. a week. And so on up to a salary of £20 a week. Increases in pay bringing the contributor into a higher salary class automatically involve increased contributions, and for the purpose of the Fund the figures are based on a maximum of £20 a week.

If the contributor should die before reaching the age of retirement his beneficiaries receive payment in full of the sum assured. If an officer reaches the £10 grade at the age, say, of 40, at 65 he will draw about £1,000 from the fund, plus accrued bonuses of £500. Thus, for an outlay on his part of £500 over the course of his service, he will receive on retirement, £1,500.

Such a scheme as that provided by the Charities Board provides for a good investment and there are withdrawal clauses which, if the assured person leaves the service before the expiry of the full term, enables return of contributions. So in any case it is a method of saving.

—The Hospital Magazine (Victoria)

Notel British Physician to Visit Canada

At the invitation of the Hon. Brooke Claxton, Minister of Health and Welfare, Sir Wilson Jameson, M.A., M.D., F.R.C.P., D.P.H., will visit Canada early in May to discuss health matters. He will also attend the annual meeting of the Canadian Public Health Association which is meeting in Toronto, May 6 to 8.

Sir Wilson Jameson has been Chief Medical Officer of the Ministry of Health and Board of Education in the United Kingdom since 1940. He is a graduate of the University of Aberdeen and of University College, London, and holds honorary degrees in law from both Aberdeen and Toronto. Among the important posts he has held is that of Dean and Professor of Public Health at the London School of Hygiene and Tropical Medicine.

Overcrowding the Hospital

Doctors at the Royal Columbian Hospital, New Westminster, B.C., found themselves confronted with this problem most vividly a few weeks ago when they discovered patients in their own cloak room!

Clinical Studies Show Why All-Bran Aids Normal Laxation

• Recent clinical studies of various foods, to compare their crude-fiber content with their influence upon laxation, indicate that previously held theories, supported by analytical technique, are no longer tenable.

Analytical investigation did not explain how Kellogg's All-Bran achieves its laxative results. It has now been demonstrated that the cellulosic content of bran supports the action of beneficent symbiotic flora which help produce soft, spongy wastes for easy elimination. Thus, All-Bran does not activate the colon itself, but stimulates the *contents* of the colon.

Furthermore, All-Bran does not work by soaking up water, nor does it produce excessive colonic distension. It neither sweeps out nor interferes with normal digestion. Reprints covering recent clinical investigations, from which these conclusions have been summarized, are available upon request: write Kellogg Company of Canada, Ltd., London, Ontario.

A Food Type Laxative

Readily Digestible

MILK MODIFIERS for INFANT FEEDING

CROWN Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.

Either may be used as an adjunct to any milk formulae.

Crown Brand and Lily White Corn Syrups are produced under the most exacting hygienic conditions by the oldest and most experienced refiners of corn syrups in Canada, an assurance of their absolute purity.

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For Doctors Only

A convenient pocket calculator, with varied infant feeding formulae employing these two famous corn syrups . . . a scientific treatise in book form for infant feeding . . . and infant formula pads, are available on request, also an interesting booklet on prenatal care. Kindly clip the coupon and this material will be mailed to you immediately.

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- ☐ Book "DEXTROSOL".

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Another Step Forward in Tbc. Management

The present time is proving to be one of the great transition periods in our handling of tuberculosis, and no better demonstration of this can be offered than the contrast between the methods of handling tuberculosis in the Armed Forces in this war, as compared with those of the last war.

Undoubtedly the greatest factor in this change was the introduction of the x-ray film as the final step in the examination of recruits for all the services in Canada, for this mass procedure has proved beyond doubt that it is possible to detect pulmonary tuberculosis in a great number of cases where detection, by the method followed in the last war, of physical examination alone, was quite impossible.

By this means it has been made clear to us that a great amount of the tuberculosis attributed to the last war was not caused by military service, but was due to a pre-war infection, and that the only harmful effect of military service was that, through unfavourable factors, it may have aggravated the condition and thus have led to a more rapid and more certain spread of disease than would normally have taken place.

By the discovery of disease in a preclinical or in a mildly active stage, two important gains have been made, for in the first place these cases of pulmonary infection have not become sources of infection in the army, and in the second place they have at once been referred to sanatoria as civilians, with the disease in an early and almost uniformly curable stage, with the result that the great majority of them have been turned back to civilian life as useful citizens.

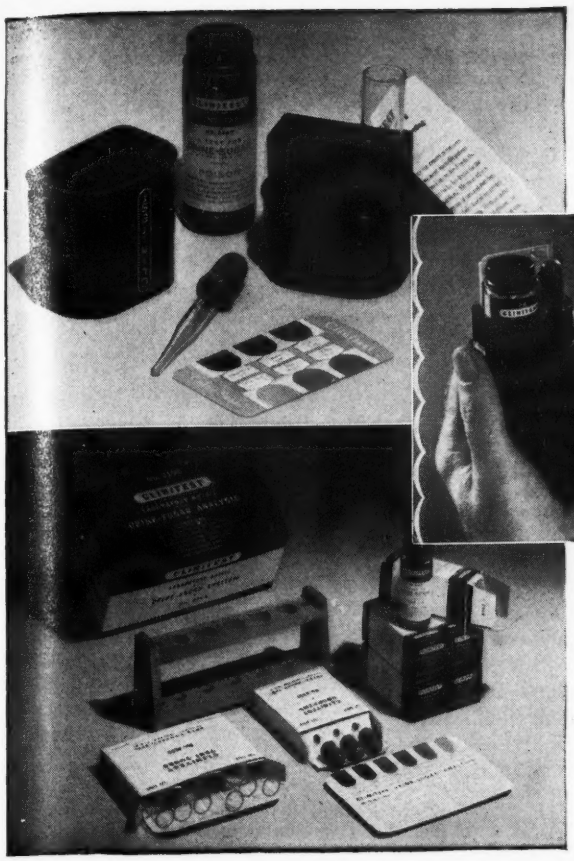
—J. H. Holbrook, M.D., F.R.C.P (C)

To Feature Electromedicine

The proposed $27,500,000 New York University College of Medicine hospital will feature electromedical equipment of all kinds, including million-volt x-ray for deep therapy, photo-roentgen apparatus, electronic stethoscopes, ultra-violet irradiation of the air; electrocardiographs, electroencephalographs, electronic heat therapy and electron microanalyzers.

A Good Law

A new public health law in Finland requires every town to have one properly qualified public health nurse per 4,000 inhabitants.



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For Urine-Sugar Analysis

PLASTIC KIT: All essentials for testing are compactly fitted into handsome, durable, Tenite Plastic case. Case contains bottle of 36 tablets, test tube, dropper, color scale and instruction sheet with analysis record. Retail Price ..... $2.25 each.

TABLET REFILL: Screw cap bottle of 36 tablets and instruction sheet with analysis record. Retail Price..... 75 cents each.

LABORATORY OUTFIT: Designed for office or laboratory use. Contains tablets for 180 tests, six test tubes, three droppers, rack and color scale with complete instructions. Retail Price ..... $5.00 each.

FOR HOSPITAL USE: Clinitest Tablets are available in bulk quantities of 1,000 and 3,000 at special prices. Put up in bottles of 100 and 250 tablets.

Order these NEW packages of CLINITEST from your medical or surgical supply house.

The reliability of the CLINITEST method has been established by experimental data and by extensive use in medical and clinical laboratories. For booklet entitled "Qualitative Determination of Urine-Sugar by the Clinitest Tablet Reagent Method", the complete chemistry and information on CLINITEST, write to Sole Canadian Distributor:

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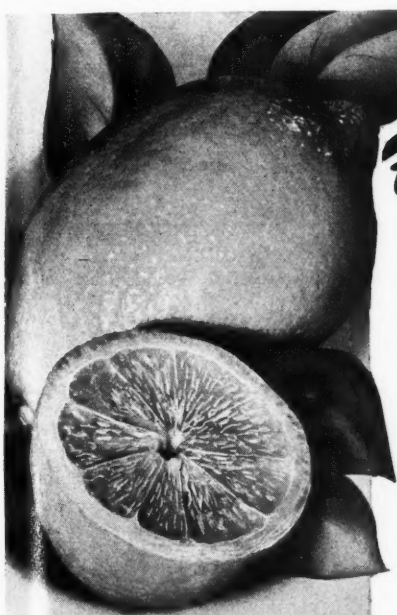

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More Canadians Admitted to College of Administrators

Four Canadian hospital administrators are listed among those approved for affiliation as nominees with the American College of Hospital Administrators. Owing to the decision of the College, with other organizations, not to meet in 1945 the status of these candidates has been declared effective as of 1945; thus not delaying their qualification for advancement.

The Canadian applicants approved are:

Horace E. Atkin, administrator, Metropolitan Hospital, Windsor, Ontario.

Donald M. Cox, secretary and manager, Municipal Hospitals, Winnipeg, Man.

John E. DeBelle, M.D., superintendent, Children's Memorial Hospital, Montreal, P.Q.

Arthur W. Smith, assistant superintendent, Royal Victoria Hospital, Montreal, P.Q.

Among the 95 administrators approved for Nomineeship were 23 Sisters. One Sister was among the fifteen who passed the written and oral examinations for membership. Twelve members have been preparing theses as a partial requirement for advancement to Fellowship but none had completely fulfilled the requirements in time for election in 1945.

Outpatient Department

(Continued from page 28)

whose duty it is to interview prospective patients and to decide upon financial eligibility must not only have certain qualities of character but also a complete knowledge of social data and the general policies of the hospital.

The outpatient department at Firmin Desloge Hospital does not operate as a separate institution without relation to the hospital, but as a part of the whole. It is one of the most important departments in which medical care and social service are intimately and mutually interested. This collaboration between the superintendent and the personnel of the institution develops a more sympathetic understanding and assures to the patient prompt and adequate professional care.

A.H.A. Retirement Plan

(Continued from page 80)

to receive a smaller pension during lifetime and continuing after death as long as his widow lives.

Withdrawal Credit to Employee. When an employee terminates employment and accepts his contribution in cash, the hospital will receive a credit based on its contributions with respect to that employee with interest.

The Committee recognized that there might be a number of hospitals which would prefer a plan more tailor-made to their own particular needs. Therefore, in support of its recommendation that all hospitals adopt some form of systematic retirement plan for their employees and to assist in the development of individual plans, the Committee prepared a discussion of the basic factors to be taken into consideration in starting such an individual plan. This was attached to their final report and recommendations to the House of Delegates of the A.H.A. and has since been published.

—Condensed from "Hospital Review", American Hospital Association.

WANTED POSITION IN PURCHASING DEPARTMENT

Ex-service man, married, age 30, well educated with several years' surgical instrument and drug purchase experience. Also experience in medical stores administration. Desires position in purchasing department or administration in established hospital. References. Box 36, The Canadian Hospital, 57 Bloor St. W., Toronto 5, Ont.

POSITIONS OPEN

in a 150-bed Hospital for qualified Night Supervisor with experience, and Chief Dietitian with ability to re-organize department. Please apply stating earliest date available to: The Superintendent, Moncton Hospital, Moncton, New Brunswick.

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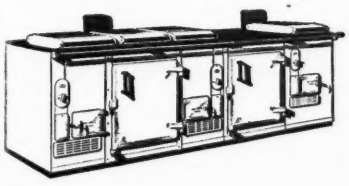
AGA ALUMINUM COOKWARE

Aga cooking engineers have designed Aga Cast Aluminum Cookware to meet the exacting demands of modern cooking with the utmost efficiency. This kitchen equipment is made to get the most out of your heating units, thereby cutting down operating costs to a minimum. The heavy, flat bottoms of Aga Cast Aluminum Cookware prevent warping and distortion and the absence of seams and rivets makes these utensils easier to clean. Now available at lowest price in 20 years. Write to Aga to-day for further information on the latest developments in kitchen ware, or call in at the Toronto or Montreal showrooms.



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- Reduces meat shrinkage to a minimum.
- Always ready for instant service.
- Increased economy, a new low in fuel costs.
- No fumes or cooking smells.
- Even heat in the ovens.
- Automatically controlled cooking temperatures.

The flat bottom of this Cast Aluminum Stock Pot is twice as thick as the sides, so that it may be used for waterless or vapour cooking, as well as ordinary boiling and stewing. Food shrinkage is reduced and mineral elements retained, giving better flavoured foods. Can be ordered in a variety of sizes from 4 to 25 gallon capacity.

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TOASTERS, URN HEATERS, AUTOMATIC GRILL and GRIDDLE, IRONS, WATER HEATERS, HEAVY DUTY HOT PLATES

Output is limited and deliveries sometimes long on account of shortages in supplies and labor and prior sales.

No. 180 Tailor Iron—18 lb.
6 sizes 8 to 18 lbs.

No. 127H Hotel Type Toasters—9 slice,
3 sizes: 3, 6 and 9 slice.

Place your order with your electrical dealer or wholesaler.

No. 153 Restaurant Automatic Combination Grill and Griddle.
4,000 Watts, 220/230 Volts. 2-wire only.

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SANITATION . . . MARCHES ON

A Boon to Better Health is Born

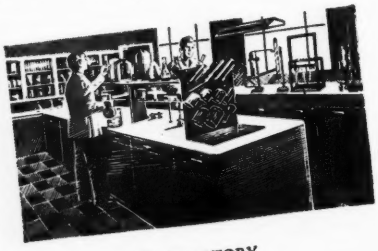
Another miracle has been born in the test tube of Science. This time R-2-L. It's an amazing new bactericide, safe and simple to use but which strikes death at pathogenic germs, wherever they are found.

The discovery of R-2-L assures sweeping improvements in health protection in factories, hospitals, schools, hotels, transit systems, railways, and wherever people congregate.

Air Borne Germs

This latest development out of the Toronto Laboratory of G. H. Wood & Company Limited acts with startling effect.

Recently Wood's Chemists were called to a dehydrating plant where the air-borne germ count seriously threatened a shutdown. In less than an hour the chemists had the plant thoroughly sanitized. Equipment, tanks, kettles were



LABORATORY
Where R-2-L was Born

flushed out, the air sprayed with a solution of one part R-2-L to five hundred parts water. When tests were taken—Lo, and behold—the germ count was the lowest in the plant's history, and remained so for a considerable period of time.

Bacteriostasis

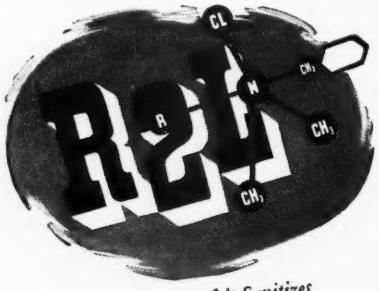
When R-2-L is used it not only kills the germs but it also makes all surfaces treated bacteriostatic, thus preventing the growth of micro-organisms which come in contact with the surface after R-2-L has been used. "Bacteriostasis" is a new word that will be heard more frequently as the public becomes conscious of its importance.

In the Movies

Yes—R-2-L is already in the movies. Recently a Wood's salesman showed a theatre manager that the odour of a raw, juicy onion rubbed on his hands disappeared completely when they were dipped in a mild solution of R-2-L. He was then shown that R-2-L quickly deodorized and sanitized washrooms, rest-rooms and even the theatre seating equipment. As a consequence, this and many other theatre chains throughout Canada are using this sensational new discovery.

Rug had "too much party"

Carpet cleaning establishments we are told are going to find R-2-L a boon for their deodorizing problems. A few weeks ago the manager of a large carpet



Presto . . . and it Sanitizes

cleaning establishment was at his wit's end to know how to deodorize a rug that obviously had been on the receiving end of "too much party" and was still somewhat odourous after repeated cleanings. The deodorizing magic of R-2-L quickly eliminated the odour in this rug much to the delighted astonishment of the rug cleaners.

Went to Jail

The age-old problem of lack of proper toilet facilities in the cells of a local jail necessitating the use of "night pails" by the inmates had its sanitizing and deodorizing problem corrected by adding R-2-L to each pail, which made the "boarding house" more like "Home Sweet Home".

The Sky is the Limit

Walter J. Evans, Wood's General Superintendent and Paul Ammann, the Company's Director of Chemical Research both agree that the uses of R-2-L in germ-killing and deodorizing are unlimited.

Spirit of Progress

The Company's bacteriological laboratory is losing no time in preparing data showing when and how R-2-L can serve, in new ways, hospitals, food processing plants, schools, railroads, steamships and the like.

Undoubtedly R-2-L has a starry future. The Company is planning to release a four-ounce package to be sold in all stores to the general public.

R-2-L is now being produced at G. H. Wood & Company's plants at Toronto, Montreal and Vancouver. Stocks are carried at most of their 24 Canadian branches. The public will find them eager to cooperate in all sanitizing and deodorizing problems. The Company's head office is located at 323 Keele St Toronto, Canada.

WOOD EVANS AMMANN
The Brains Behind the Achievement

* *R-2-L is the registered trade and the property of G. H. Wood & pany Limited of Toronto, Canada*

G. H. WOOD & COMPANY LIMITE